

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item # Film G34 1/5/67 mm

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

16403

16402

~~b2~~
~~b3~~
~~b4~~
~~b5~~

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE West Virginia COUNTY Mineral	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 7 Hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS -----	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Harry Edward Abe		First Harry	Middle Edward
4. DATE OF DEATH December 27 1966	Month Day Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-22-06
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman		10b. KIND OF BUSINESS OR INDUSTRY Railroad	9. AGE (In years last birthday) 61/60 yrs.
13. FATHER'S NAME Nimrod Abe		14. MOTHER'S MAIDEN NAME Marry Balden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	17. INFORMANT Memorial Hospital, Cumberland, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) DUE TO (c)		Address INTERVAL BETWEEN ONSET AND DEATH Hours	
Coronary Occlusion		"	
Coronary Thrombosis		"	
Coronary Sclerosis		*-----*	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Mitral Stenosis; Left Ventricular Hypertrophy, Marked.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 30, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Abe Cemetery		23d. LOCATION (City or Town) (County) (State) Near Ridgeley, W.Va.	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE JAN 3 1967	25b. REGISTRAR'S SIGNATURE Charles J. Scarpelli

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The least remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16403

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 79 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
3. NAME OF DECEASED (Type or print) DAVID R. ALLEN		First DAVID	Middle R.
4. DATE OF DEATH DECEMBER 5 1966	Month DECEMBER	Day 5	Year 1966
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 12-24-95
9. AGE (In years last birthday) 70 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) VARIOUS	10b. KIND OF BUSINESS OR INDUSTRY FACTORY	11. BIRTHPLACE (County & State, or foreign country) MARYLAND	
13. FATHER'S NAME CHARLES ALLEN	14. MOTHER'S MAIDEN NAME EURECKA CASSIDY	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. 214v 07 2912	17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Since 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Atherosclerosis DUE TO Sept 17-66 (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 9-17-1966
20f. (City or town) 12-5-66		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-17-1966 to 12-5-66 , that (I) (we) last saw the deceased alive on 12-4-66 and that death occurred at 50 AM . All causes and all the date stated above.			
22a. SIGNATURE <i>W. F. Williams</i>		22b. DATE SIGNED 12-5-66	
22c. PHYSICIAN'S NAME (Type) DR. W.F. WILLIAMS		22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC. 7, 1966	23c. NAME OF CEMETERY OR CREMATORIAL HILLCREST BURIAL PARK
23d. LOCATION (City or Town) CUMBERLAND, MD.		(County) (State)	
24. FUNERAL DIRECTOR BYRON KIGHT		25a. ADDRESS CUMBERLAND, MD.	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
		25a. REC'D BY REGISTRAR DEC 8 1966	25b. REGISTRAR'S SIGNATURE

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19 JULY 1964

FEDERAL BUREAU OF INVESTIGATION

U.S. DEPARTMENT OF JUSTICE

WASH. D.C. 20535

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DEPT. OF JUSTICE

14 JULY 1964

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

16405

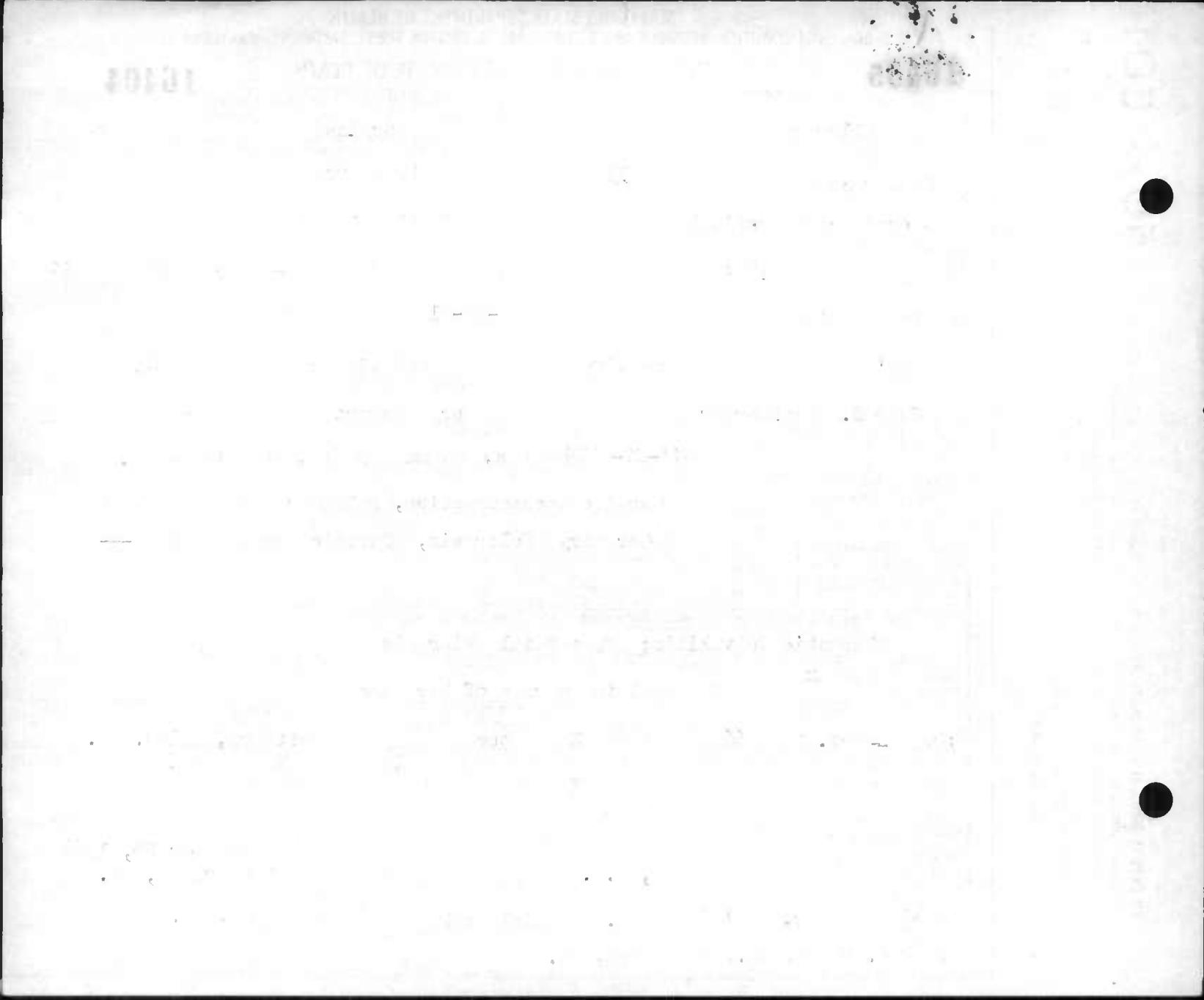
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16404

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1. PLACE OF DEATH o. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 33	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Nellie V Bean		4. DATE OF DEATH December 28 1966	Month Day Year
S. SEX Female	6. COLOR OR RACE White	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-23-81
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (State or foreign country) West Virginia
13. FATHER'S NAME John S. Hershberger		14. MOTHER'S MAIDEN NAME Mary Rogers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 214-01-6675D	17. INFORMANT Mrs. Victor Hawkins, Frostburg, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		Cardiac Decompensation, Pulmonary Edema Days Coronary Sclerosis, Chronic Myocarditis ---	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Rheumatic Valvulitis; Myocardial Fibrosis			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell in bedroom of her home	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 8:00 Nov. 24 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) Frostburg, Alleg. Md.		(County) Allegany	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 30 '66	
23c. NAME OF CEMETERY OR CREMATORIAL Fbg. Memorial Park		23d. LOCATION (City or Town) (County) (State) Frostburg, Md.	
24. FUNERAL DIRECTOR Joseph R. Durst, Sr., Frostburg, Md.		ADDRESS	25a. REC'D BY REGISTRAR JAN 3
		DATE	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																							
CERTIFICATE OF DEATH																							
16406				16405																			
1. PLACE OF DEATH a. COUNTY ALLEGANY				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT																			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 14 DAYS																			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print)		First HARRY	Middle J	Last BENDER	4. DATE OF DEATH 12/14/66	Month 12	Day 14	Year 1966															
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> WIDOWED	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 9/27/02	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months 0		IF UNDER 24 HRS. Days 0		Hours 0	Min. 0											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dispenser Clerk				10b. KIND OF BUSINESS OR INDUSTRY Garr. Co. Comm.				11. BIRTHPLACE (County & State, or foreign country) Springs, Pa.				12. CITIZEN OF WHAT COUNTRY? USA											
13. FATHER'S NAME Jacob J. Bender				14. MOTHER'S MAIDEN NAME Carrie Fogle				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 214-03-7105				17. INFIRMARY PATIENT'S CHART (Mrs. Jane Garleets)				Address Friendsville Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH 5 WKS																			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1				Metastatic Carcinoma to liver																			
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b)				Gyno-hormone carcinoma, oat cell type								?											
DUE TO (c)																							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) Grantsville		(County) GARRETT		(State) Md.							
21. I certify that (I) (this hospital) attended the deceased from 12-4 , 1966, to 12-14 , 1966, that (I) (we) last saw the deceased alive on 12-13 1966 , and that death occurred at 2 A.M. from the causes and on the date stated above.												22b. DATE SIGNED 12-14-66											
22a. SIGNATURE W. Springer				22d. ADDRESS								M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>											
22c. PHYSICIAN'S NAME (Type) DRS. CLICK & SPIGGLE																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12/16/66				23c. NAME OF CEMETERY OR CREMATORIAL Grantsville Cem.				23d. LOCATION (City, town or county) Grantsville, Garrett, Md.				(State)							
24. FUNERAL DIRECTOR Don Newman				ADDRESS Grantsville, Md.				25a. REC'D BY REGISTRAR DEC 21 1966				25b. REGISTRAR'S SIGNATURE James Judge				DATE							

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1 To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 8,9 Film 6384 12/27/66 mh

15407

CERTIFICATE OF DEATH

16406

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) d. STATE MARYLAND		b. COUNTY ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 4 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 445 RACE ST.		4. DATE OF DEATH DEC. 5 1966		Month Day Year					
3. NAME OF DECEASED (Type or print)	First MAY	Middle J.	Last BENNETT	B. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1884 5-30-1884	9. AGE (In years last birthday) 82 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home			11. BIRTHPLACE (County & State, or foreign country) ROMNEY, W. VA.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOHN PYLES				14. MOTHER'S MAIDEN NAME Geneteea Brown				Address CUMBERLAND, MD.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Herniated Intervertebral Discs</i>				DUE TO <i>422.1</i>				INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Respiratory Disease</i>				DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> At work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>1934</i>		(County) <i>1966</i>		(State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1934</i> to <i>1966</i> , that (I) (we) last saw the deceased alive on <i>Dec. 6, 1966</i> , and that death occurred at <i>12:00 P.M.</i> from causes and on the date stated above.											
22a. SIGNATURE <i>G. Overton Himmelwright</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>12/8/66</i>			
22c. PHYSICIAN'S NAME (Type) DR. G. OVERTON HIMMELWRIGHT		22d. ADDRESS 133 VA. AVE., CUMBERLAND, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 10, 1966		23c. NAME OF CEMETERY OR CREMATORIALY Zion Memorial Park		23d. LOCATION (City or Town) Cumberland, Md. Allegany		(County) (State)			
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE DEC 12 1966					
VR A15 (4) 20 M 1/66											

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16407

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE WEST VIRGINIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 40 MIN.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MOUTH OF SENECA 85.3	
3. NAME OF DECEASED (Type or print) First Timothy Middle MICHAEL Last BOGAN		4. DATE OF DEATH Month DECEMBER Day 21, Year 1966	
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-21-66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ELMER -- Champ		14. MOTHER'S MAIDEN NAME BOGAN, REGENA M.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>7593</i>		16. SOCIAL SECURITY NO. 17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Cardiac Decompensation</i>		INTERVAL BETWEEN ONSET AND DEATH <i>min wks</i>	
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) DUE TO <i>Congenital lung</i> (c) DUE TO <i>Congenital abnormality</i>		Congenital <i>[signature]</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <i>Fetal Anoxia Generalized</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <i>12/21/66</i> 12/21/66	
21. I certify that (I) (this hospital) attended the deceased from <i>12:03 PM</i> , <i>1966</i> to <i>12:25 PM</i> , <i>1966</i> , that (I) (we) last saw the deceased alive on <i>12/21</i> <i>1966</i> , and that death occurred at <i>12:25 PM</i> , <i>1966</i> , from causes and on the date stated above.		22b. DATE SIGNED <i>12/22/66</i>	
22c. PHYSICIAN'S NAME (Type) DR. L. LOUIS MOULD (Pathologist)		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 12-23-66		23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL VAN DE YANDER FAMILY 23d. LOCATION (City or Town) (County) (State) CHERRY GROVE PENDLETON W. VA	
24. FUNERAL DIRECTOR MR. ARLYN S. ARNOLD - PETERSBURG, W. VA.		ADDRESS 24a. REC'D BY REGISTRAR DATE DEC 23 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16409

CERTIFICATE OF DEATH

16408

1. PLACE OF DEATH a. COUNTY Allegany Co.		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE West Virginianb. COUNTY Mineral	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, W. Va.		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Sacred Heart Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgeley W. Va.	
52		d. STREET ADDRESS 9 Wabash St.	
3. NAME OF DECEASED (Type or print) Joseph F. Bowers		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH 12-2-56		Day Year 19 66	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-3-07	
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		10b. KIND OF BUSINESS OR INDUSTRY Kelly Tire Co.	
11. BIRTHPLACE (County & State, or foreign country) Ridgeley, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frank Bowers		14. MOTHER'S MAIDEN NAME Elizabeth Maiers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 214-05-9915	
17. INFORMANT Mrs. Esta S. Bowers		Address W. Va. 9 Wabash St. Ridgeley,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 163X	
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b)		DUE TO	
(c)		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Jerry</i> , 1966, to <i>1966</i> , 1966, that (I) (we) last saw the deceased alive on <i>Dec. 1 1966</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.		22b. DATE SIGNED 12-3-66	
22a. SIGNATURE <i>John Schindler</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Blane M. Schindler, M.D.		22d. ADDRESS 43 Greene St. Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/6/66	
23c. NAME OF CEMETERY OR CREMATORIALy		23d. LOCATION (City, town or county) (State) Cumberland, Allegany Md.	
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Maryland		ADDRESS	
		25a. REC'D BY REGISTRAR DATE DEC 6 1956	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

20131

Common fresh berries

100%

50%

25%

10%

5%

2%

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16410

CERTIFICATE OF DEATH

16410

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**To FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN lb 3 Weeks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ESTHER Esther Victoria Broadwater		First E	Middle S
4. DATE OF DEATH Dec. 14, 1966	Month Dec.	Day 14	Year 1966
5. SEX F	6. COLOR OR RACE W	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH July 6, 1902	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sec'y. Midtown Motors, Canton, Ohio	10b. KIND OF BUSINESS OR INDUSTRY Canton, Ohio	11. BIRTHPLACE (County & State, or foreign country) Grantsville, Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Charles A. Bender	14. MOTHER'S MAIDEN NAME Emma Yutzy	Address Chas. O. Bender, Grantsville, Md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 000-00-0000	17. INFORMANT Chas. O. Bender, Grantsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Primary carcinoma right lung			
DUE TO 162.1			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 6 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) At home
20f. (City or town) Grantsville		(County) Md.	(State) Md.
21. I certify that (I) (this hospital) attended the deceased from Nov. 22, 1966 , to Dec. 14, 1966 , that (I) (we) last saw the deceased alive on Dec. 13, 1966 , and that death occurred at Grantsville , from causes and on the date stated above.			
22a. SIGNATURE G. Page Strong		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. G. Page Strong	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) G. Page Strong		22b. DATE SIGNED Dec. 21, 1966	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/17/66	23c. NAME OF CEMETERY OR CREMATORIAL Salisbury I.O.O.F. Cem.
23d. LOCATION (City or Town) Salisbury, Somerset, Pa.		(County) Somerset Co., Pa.	(State) Pa.
24. FUNERAL DIRECTOR Non J Newman		ADDRESS Grantsville, Md.	25a. REC'D BY REGISTRAR Charles Judge
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE DEC 21 1966	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16411

CERTIFICATE OF DEATH

16410

1. PLACE OF DEATH o. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Md.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 8 Days				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) James Albert Broadwater		First James	Middle Albert			
S. SEX M	6. COLOR OR RACE W	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH Dec. 28, 1873		9. AGE (In years lost birthday) 93 yrs.	10. IF UNDER 1 YEAR Months 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	11. BIRTHPLACE (County & State, or foreign country) Garrett Co., Md.			
13. FATHER'S NAME John A. Broadwater		14. MOTHER'S MAIDEN NAME Mary (Custer)				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---	17. INFORMANT Mrs. Eva Lewis, Frostburg, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.0		INTERVAL BETWEEN ONSET AND DEATH days & months				
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause arteriosclerotic						
(b) DUE TO						
(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) ---	(County) ---	(State) ---
21. I certify that (I) (this hospital) attended the deceased from 12/13/66 to 12/30/66 , that (I) (we) last saw the deceased alive on 12/30/66 , and that death occurred at 12:00 AM , from causes and on the date stated above.						
22a. SIGNATURE John B. Davis		M.D. <input type="checkbox"/> ATTENDING PHYS. John B. Davis, MD	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. John B. Davis, MD	22b. DATE SIGNED 12		
22c. PHYSICIAN'S NAME (Type) John B. Davis, MD		22d. ADDRESS 2 Broadway, Frostburg				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/2/67	23c. NAME OF CEMETERY OR CREMATORIAL Robeson Cemetery	23d. LOCATION (City or Town) Avilton, Garrett, Md.	(County) ---	(State) ---
24. FUNERAL DIRECTOR Ruth E. Newland		ADDRESS Grantsville, Md.	25a. REC'D BY REGISTRAR JAN 5 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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16412

CERTIFICATE OF DEATH

16411

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 2/8/1965					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Jane	Middle Grey	Last Cessna				
4. DATE OF DEATH December 20, 1966	Month	Doy	Year				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/5/1875	9. AGE (In years last birthday) 91 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME J. Holmes Houck		14. MOTHER'S MAIDEN NAME Jane Powell					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. —		17. INFORMANT P.O. Box 599, Cumberland, Md. Allegany County Infirmary records.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (3) Cerebral Apoplexy & left Hemis. plegia (c) (4) Bilateral Cerebrots						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/8/65, 19, to 12/20/1966, that (I) (we) lost saw the deceased alive on 12/20/1966, and that death occurred at A. M, from causes and on the date stated above.				at 11:30 A. M.		22b. DATE SIGNED 12/21/1966	
22c. PHYSICIAN'S NAME (Type) Lee B. Mathews, M. D.		22d. ADDRESS 49 Greene St., Cumberland, Md.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/23/66		23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cem.		23d. LOCATION (City or Town) (County) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR Louis Stein Inc.		ADDRESS Cumb. Md.		25a. REC'D BY REGISTRAR DEC 27 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	
VR A15 (4) 20 M 1/66							

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16413

CERTIFICATE OF DEATH

16412

1 To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

2 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 1 DAY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> d. STREET ADDRESS 470 SPRUCE STREET	
3. NAME OF DECEASED (Type or print) LILY		First E.	Middle COOK
4. DATE OF DEATH DEC. 30 1966		Last COOK	Month Doy Year
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-11-1914
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) 51 yrs.
			11. BIRTHPLACE (County & State, or foreign country) MARYLAND
13. FATHER'S NAME JOHN ELIAS		14. MOTHER'S MAIDEN NAME LAURA E. WELSH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD. Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1918 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Arteria - Cerebra & Cervix trici		INTERVAL BETWEEN ONSET AND DEATH 5 1/2 yrs	
DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 1961
21. I certify that (I) (this hospital) attended the deceased from 1961 , 19 to 1966 , 19, that (I) (we) last saw the deceased alive on 12-30-65 1965 and that death occurred on 12-30-65 1965 from causes and on the date stated above.		(City or town) (County) (State)	
22a. SIGNATURE Louis J. Mould		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) L. LOUIS MOULD, MD.		22d. ADDRESS 1068 NATIONAL HWY, LA VALE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 3, 1967	23c. NAME OF CEMETERY OR CREMATORIAL St. Peters
24. FUNERAL DIRECTOR G. L. Boal		ADDRESS Westernport, Md.	25a. REC'D BY REGISTRAR DATE JAN 6 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

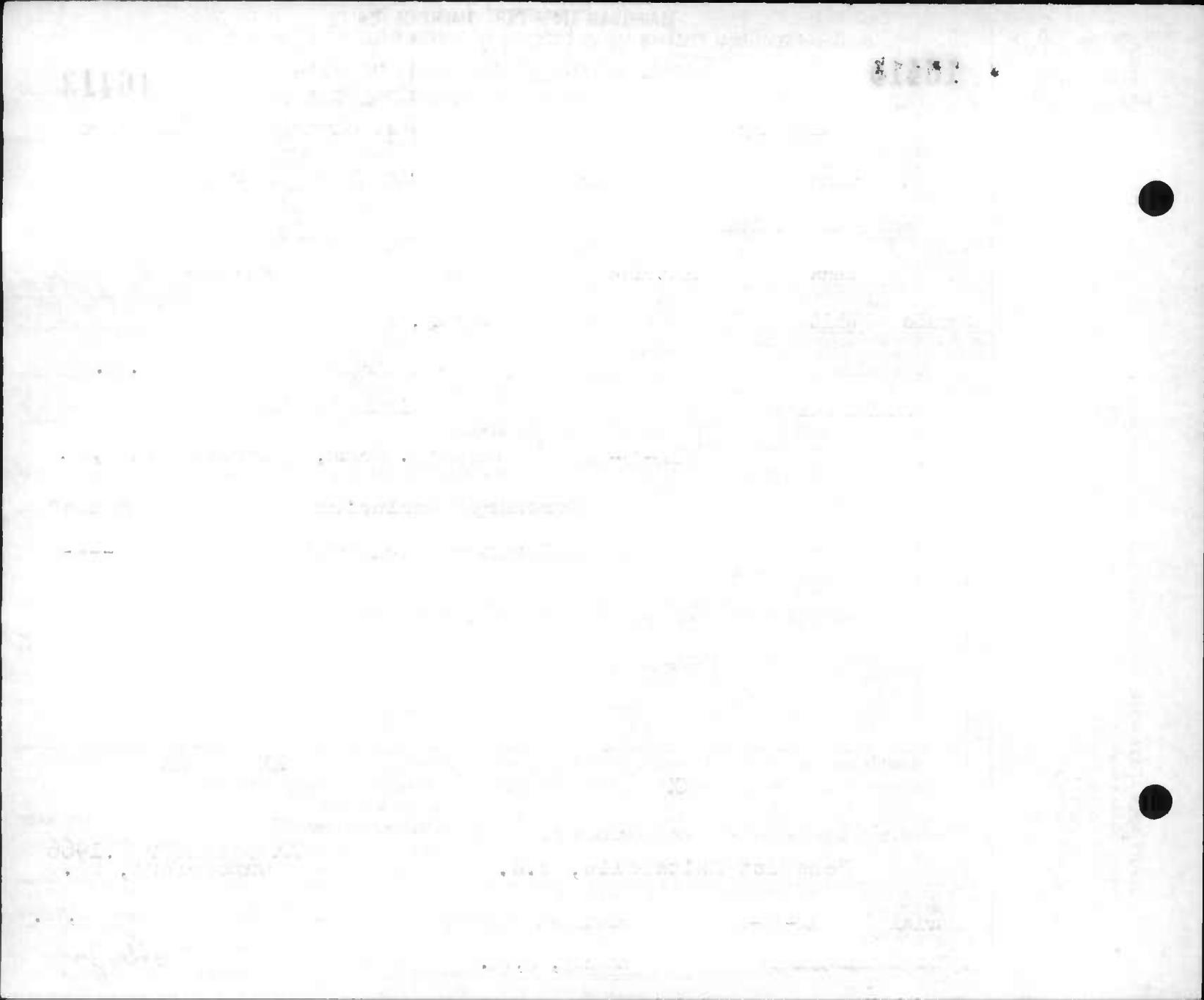
10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Be pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

16414

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16413

1. PLACE OF DEATH o. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE West Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb Minutes	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Lena	Middle Beatrice	4. DATE OF DEATH December 8 1966
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 13, 1911
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) 55 yrs.
13. FATHER'S NAME William Chippis		11. BIRTHPLACE (State or foreign country) West Virginia	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <input type="checkbox"/> No		16. SOCIAL SECURITY NO. 214-05-5478	17. INFORMANT Lester T. Crock, Address Springfield, W. Va.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
Coronary Occlusion		Coronary Sclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> December 8, 1966 Address (Street, city, town, or county) Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-11-66	23c. NAME OF CEMETERY OR CREMATORY McCuthean Cemetery
24. FUNERAL DIRECTOR <i>Dale Shaffer</i>		23d. LOCATION (City or Town) (County) (State) Ireland Lewis W. Va.	
ADDRESS Romney, W. Va.		25a. REC'D BY REGISTRAR Charles Judge	
DATE DEC 13 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16415

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16414

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland Md.		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Daisy D. Cromwell.		First	Middle
		Last	4. DATE OF DEATH Dec. 21, 1966
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 1/1/83		9. AGE (In years last birthday) 83 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Winchester Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO.	
17. INFORMANT Eldred A. Cromwell		Address Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
Coronary Occlusion			
Coronary Sclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/24/66	
23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cem.		23d. LOCATION (City or Town) (County) (State) Cumberland Md. (Allegany)	
24. FUNERAL DIRECTOR <i>Louis Stein Inc. Cumberland Md.</i>		25a. REGD BY REGISTRAR DEC 27 1966	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16416

CERTIFICATE OF DEATH

16415

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First RAE	Middle NMI	Last CROSS
4. DATE OF DEATH 12/14/66	Month 19	Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11/19/97
WIOOWEO <input type="checkbox"/>	MALE <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Former Custodian	10b. KIND OF BUSINESS OR INDUSTRY State Hosp.	11. BIRTHPLACE (County & State, or foreign country) W. Va. Berkeley Springs	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Cross	14. MOTHER'S MAIDEN NAME Mary Yost Cross	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 082-01-0430	17. INFORMANT PATIENT'S CHART	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Respiratory Failure DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Embolism DUE TO (c) 10 yrs			
INTERVAL BETWEEN ONSET AND DEATH 75 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERRLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5-20 , 19 66 , to 12-14 , 19 66 , that (I) (we) last saw the deceased alive on 12-13 19 66 , and that death occurred at 64 M, from the causes and on the date stated above.			
22a. SIGNATURE <i>W.C. Spiggle</i>	22b. DATE SIGNED 12/14/66		
22c. PHYSICIAN'S NAME (Type) Drs. GLICK & SPIGGLE Wayne C. Spiggle, M.D.	22d. ADDRESS 126 N. Smallwood St. Cumberland, Md.	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial	23b. DATE THEREOF 12/17/66	23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park	23d. LOCATION (City, town or county) (State) Cumberland, Allegany Md.
24. FUNERAL DIRECTOR H. Wayne George	ADDRESS Cumberland, Md.	25a. REC'D BY REGISTRAR DEC 19 1966	25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>
VR A15 (4) 20M 1/65	BP	DATE	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16417

CERTIFICATE OF DEATH

16416

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 54 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS N. Centre St.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sylvan Retreat				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Carrie		First	Middle	Lost	4. DATE OF DEATH December 17 1966	Month	Doy	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 8/5/78	9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. DAYS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Allegany, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Jacob Halderman				14. MOTHER'S MAIDEN NAME Mary O'Farrell				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Hugh O'Rourke		Address Cumberland, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (Hyperreflexic abx. degenerative) 4221 DUE TO (Astrois Sclerosis, general + cerebral) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (Mental Deficiency & psychosis, G.O. 12) (c)								INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 11/25 , 19 36 , to 12/17 , 19 66 , that (I) (we) last saw the deceased alive on 12/16 19 66 , and that death occurred at 10 A.M. from causes and on the date stated above.								
22a. SIGNATURE W. B. Mathews		22b. DATE SIGNED						
M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								
22c. PHYSICIAN'S NAME (Type) L. B. Mathews		22d. ADDRESS 49 Greene Street, Cumberland, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC. 20, 1966		23c. NAME OF CEMETERY OR CREMATORIUM ST. PATRICKS CEMETERY		23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.		
24. FUNERAL DIRECTOR BYRON KIGHT		ADDRESS CUMBERLAND, MD.		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge		

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16418

CERTIFICATE OF DEATH

16417

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY HAMPSHIRE		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GREENSPRINGS		c. LENGTH OF STAY IN 1b Cumberland 6 DAYS	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE WEST VIRGINIA		b. COUNTY HAMPSHIRE
					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GREENSPRINGS, W. VA.		85.3
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First O'FARRELL	Middle B.	Lost DAY	4. DATE OF DEATH	Month DEC.	Day 7	Year 1966
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-2-01	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS. Hours 16 hrs.	Min. 30
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) BERKELEY SPRINGS, WVA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH R. YOST			14. MOTHER'S MAIDEN NAME ADA V. ALLEN				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		Address MEMORIAL HOSPITAL CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decomposition - Chr. Passive Congestion 460.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction DUE TO (c) ARTERIAL Ocularis Ventricular Tachycardia 6 yrs. 16 hrs.							
INTERVAL BETWEEN ONSET AND DEATH 5 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Diphtheritis of Colon							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Oct 18 1966 to Dec 7 1966 , that (I) (we) last saw the deceased alive on Dec 7 1966 , and that death occurred 5:15 P.M. from causes and on the date stated above.							
22c. PHYSICIAN'S NAME (Type) DR. D. B. GROVE		22b. DATE SIGNED MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 10, 1966	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mt. Tabor	23d. LOCATION (City or Town) (County) (State) Berkeley Springs, W.Va.			
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS JAMES F. SCARPELLI, CUMBERLAND, MD.		25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
16419								16418							
1. PLACE OF DEATH a. COUNTY Allegany				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland				b. COUNTY Allegany							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b c. CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				d. STREET ADDRESS 429 Columbia Street							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Sacred Heart Hospital								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Taylor	Middle H.	Last Day	Month	Day	Year	4. DATE OF DEATH 12	Month	Day	Year				
5. SEX Male		6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/16/77	9. AGE (in years last birthday) 89 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	Hours 0	Min. 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER				10b. KIND OF BUSINESS OR INDUSTRY SAWMILLS				11. BIRTHPLACE (County & State, or foreign country) West Virginia				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Adam Day				14. MOTHER'S MAIDEN NAME Mildred Simmons											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 220-52-9793				17. INFORMANT patient's chart				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]															
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Secondary of underlying condition</i>															
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coming after disease CVA</i> (c) <i>Paroxysmal Epilepsy</i>															
INTERVAL BETWEEN ONSET AND DEATH <i>years days hours</i>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Nov. 28, 1966</i> , to <i>Dec 19, 1966</i> , that (I) (we) last saw the deceased alive on <i>Nov. 15, 1966</i> , and that death occurred at <i>M.</i> from the causes and on the date stated above.															
22a. SIGNATURE <i>Charles J. Schindler</i>				22b. DATE SIGNED <i>12/19/66</i>											
22c. PHYSICIAN'S NAME (Type) BLANE SCHINDLER, M.D.				M.D. ATTENDING PHYS. <input type="checkbox"/>				MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF DEC. 21, 1966				23c. NAME OF CEMETERY OR CREMATORIUM ALLEGANY COUNTY CEMETERY				23d. LOCATION (City, town or county) (State) CUMBERLAND, MD.			
24. FUNERAL DIRECTOR BYRON KIGHT				ADDRESS CUMBERLAND, MD.				25a. REC'D BY REGISTRAR DEC 27 1966				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
VR A15 (4) 20M 1/65								DATE							

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FOR STATE
HEALTH DEPT.

Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

16420

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16419

13

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN 1b

DOA

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Memorial Hospital

99
3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

Chester

Roy

4. DATE
OF
DEATH

Dec.

30 1966

Month

Dey

Year

5. SEX

6. COLOR OR RACE

Male

White

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

10/30/03

9. AGE (In years
last birthday)

63 yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Bricklayer

10b. KIND OF BUSINESS OR INDUSTRY

Contractor

11. BIRTHPLACE (State or foreign country)

Ridgeley, W. Va.

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13. FATHER'S NAME

Israel Detrick

14. MOTHER'S MAIDEN NAME

Carrie Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

No,

16. SOCIAL SECURITY NO.

236-12-9391

17. INFORMANT

Mrs. Velma Detrick R.D. # Ridgeley, W. Va.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Asphyxiation

INTERVAL BETWEEN
ONSET AND DEATH
Minutes

9/21
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.
(b)

DUE TO

DUE TO

(c)

Compression of Chest and Abdomen

Minutes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)

Pinned under overturned Farm Tractor

20c. TIME OF INJURY Month, Day, Year

1:45
Hour

p.m.

Dec. 30 1966

While at work

Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Farm Rt. 1 Ridgeley, Mineral, W. Va.

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER December 30, 1966

Address (Street, city, town, or county) Cumberland, Md.

22e. BURIAL, CREMATION, REMOVAL, (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or country) (State)

Burial 1/2/67 Hillcrest Burial Park Cumberland, Allegany, Md.

23. FUNERAL DIRECTOR ADDRESS REC'D BY REGISTRAR REGISTRAR'S SIGNATURE

H. Wayne George Cumberland, Md. DATE JAN 4 1967 Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any de-

re necessary,

please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral

director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 may be retained for your files.

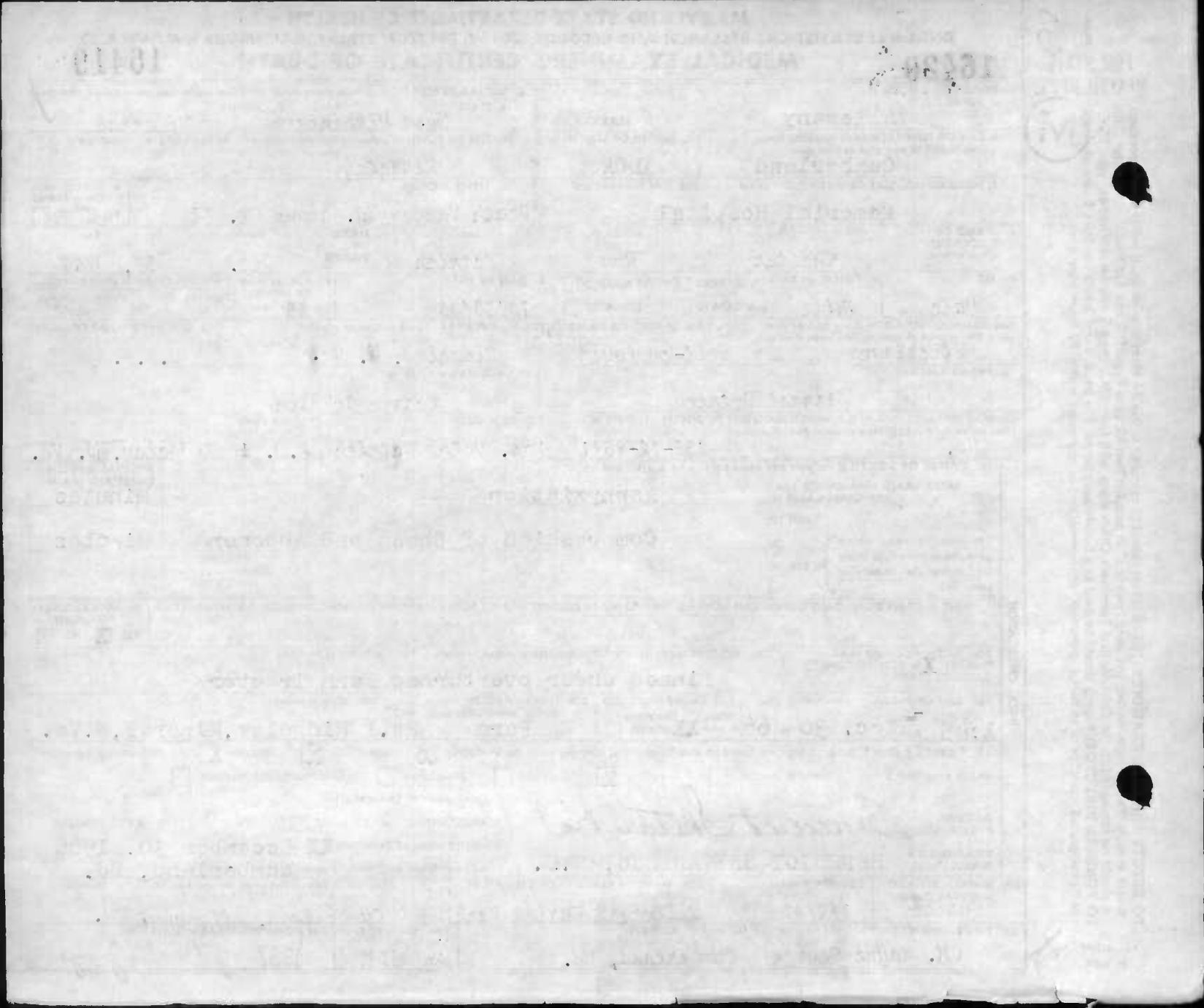
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

88

2

MEDICAL CERTIFICATION

V. A15ME
5M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

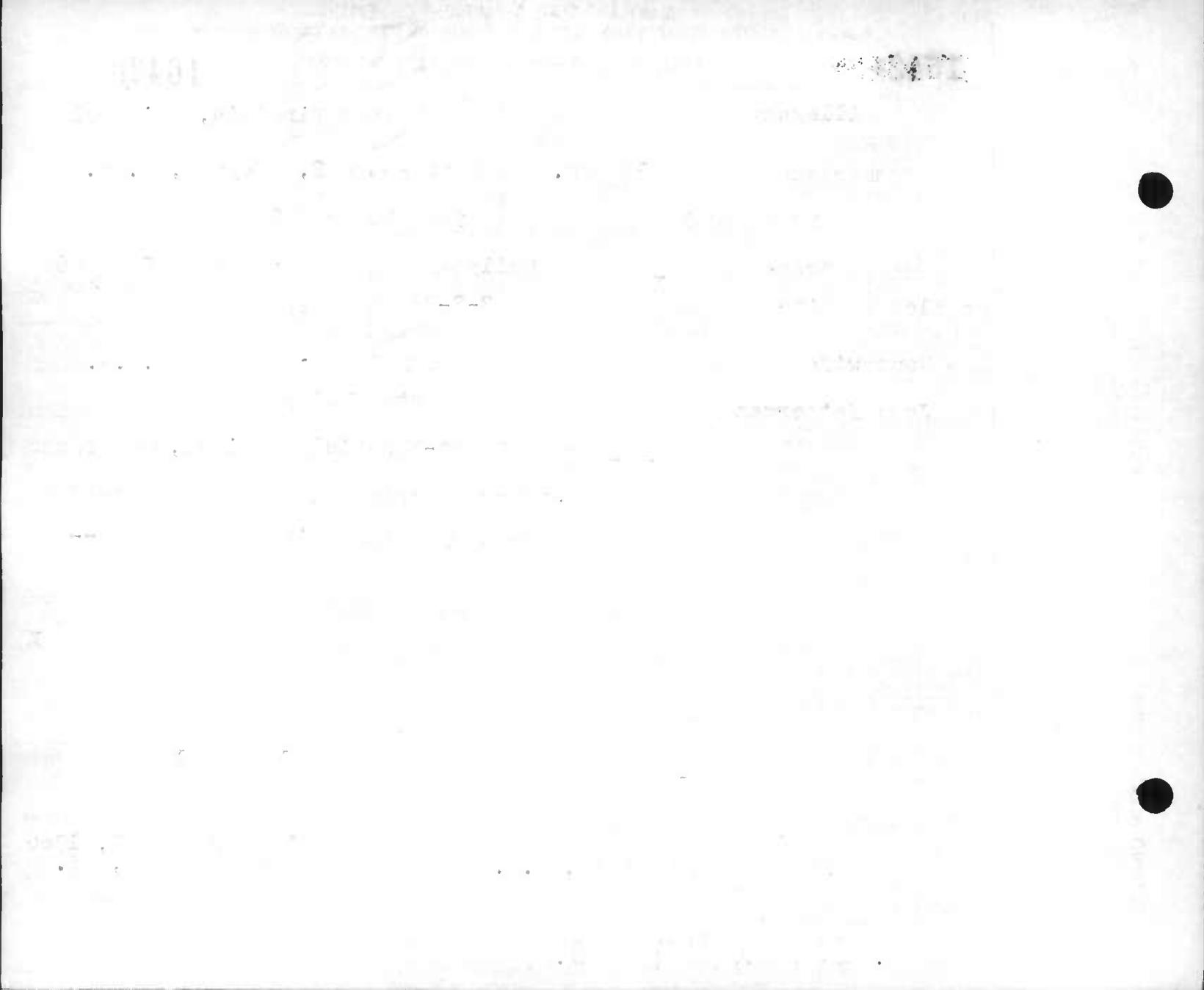
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

16421

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16420

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE West Virginia COUNTY Mineral ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 2½ Hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Grace Middle Dolly		4. DATE OF DEATH December 2 1966 Month Day Year	
S. SEX Female 6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 7-2-98		9. AGE (In years last birthday) yrs. 68 IF UNDER 1 YEAR Months Days Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) West Virginia	
13. FATHER'S NAME John Ketterman		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 236-58-0831	
17. INFORMANT Chart-Memorial Hospital, Cumberland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH Sudden			
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Sclerosis (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> December 2, 1966 Address (Street, city, town, or county) Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 5, 1966	
23c. NAME OF CEMETERY OR CREMATORY Oakdale Methodist Cemetery		23d. LOCATION (City or Town) (County) (State) Near Flintstone, Maryland	
24. FUNERAL DIRECTOR John J. Hafer ADDRESS		25a. REGISTERED BY REGISTRATION DATE 1966	
John J. Hafer, Jr., 230 Baltz Ave., Cumberland, Md.		25b. REGISTRAR'S SIGNATURE <i>J. Hafer</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16422

CERTIFICATE OF DEATH

16421

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 10 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First LUCILLE	Middle E.	Last DOOLITTLE
4. DATE OF DEATH DECEMBER 18 1966	Month	Day	Year
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-6-96
9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SCHARF JERE		14. MOTHER'S MAIDEN NAME LAYMAN, FRANCES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>/</i>	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD. Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Acute coronary occlusion</i>		INTERVAL BETWEEN ONSET AND DEATH minutes	
DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause <i>420.1</i>			
(b) DUE TO <i>Arteriosclerotic cardiovascular disease</i> 10 years			
(c) DUE TO <i>with several old strokes and one old myocardial infarction.</i> (?)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from December 18, 1966, Dec. 18, 1966 that (I) (we) last saw the deceased alive on Dec. 18th 1966, and that death occurred at 105 P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>Wyand F. Doerner</i>		22b. DATE SIGNED 12-21-66	
22c. PHYSICIAN'S NAME (Type) DR. WYAND F. DOERNER		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF 12/21/66	23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cem.
23d. LOCATION (City or Town) (County) (State) Cumb. Md.		23e. REG'D BY REGISTRAR DATE DEC 27 1966	
24. FUNERAL DIRECTOR ADDRESS <i>Lewis Stein Inc. Cumb. Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

18101

1940-10-14 1940-10-14

18102

1940-10-14 1940-10-14
1940-10-14 1940-10-14

1940-10-14

1940-10-14

1940-10-14

1940-10-14

1940-10-14

1940-10-14

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

16423

CERTIFICATE OF DEATH

16422

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 328 Cumberland St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Coletta	Middle M.	Last Durbin	4. DATE OF DEATH 12	Month 13	Day 19	Year 66
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/17/91	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 70		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Allegany Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William H. Doerner		14. MOTHER'S MAIDEN NAME Mary L. (Firle) Doerner					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 70		16. SOCIAL SECURITY NO. 220-44-7728		17. INFIRMITY patient's chart		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory failure <i>420.1</i> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction and stroke DUE TO (c) Cerebral and coronary sclerosis							
INTERVAL BETWEEN ONSET AND DEATH 12 hours							
5½ months							
5 (?) yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 30th, 1966 , to Dec. 13th, 1966 , that (I) (we) last saw the deceased alive on Dec. 13th, 1966 , and that death occurred at 6:30 PM , from the causes and on the date stated above.		22b. DATE SIGNED 12-11-66					
22a. SIGNATURE <i>Wyand F. Doerner, Jr., M.D.</i>		22b. DATE SIGNED 12-11-66					
22c. PHYSICIAN'S NAME (Type) Wyand F. Doerner, Jr., M.D.		22d. ADDRESS 414 N. Mechanic St., Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/15/66		23c. NAME OF CEMETERY OR CREMATORIUM St. Peter + Paul Cemetery		23d. LOCATION (City, town or county) (State) Cumb. Md.	
24. FUNERAL DIRECTOR Lewis Stein Inc. Cumb. Md.		ADDRESS		25a. REC'D BY REGISTRAR DEC 19 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	
B P				DATE			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16424

CERTIFICATE OF DEATH

16423

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,		c. LENGTH OF STAY IN 1b 10 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 631 N. CENTRE STREET		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First CLARENCE	Middle R	Lost DYCHE	4. DATE OF DEATH DECEMBER 13 1966	Month DECEMBER	Doy 13	Year 1966
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 7, 94	9. AGE (In years 72 birthday yrs.)	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Street Dept Supervisor Cumberland		10b. KIND OF BUSINESS OR INDUSTRY City of		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME GEORGE DYCHE				14. MOTHER'S MAIDEN NAME Wilhemina Dill				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-36-9033		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 420.1 Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost: (b) (c)		DUE TO Coronary Insufficiency Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 17/13		(County) 1966
21. I certify that (I) (this hospital) attended the deceased from 17/13 , 1966, to 17/13 , 1966, that (I) (we) last saw the deceased alive on 17/13 , 1966, and that death occurred at 12:15 P.M. , from causes and on the date stated above.								
22. SIGNATURE Leo H. Ley Jr.						22. DATE SIGNED 17/12/1966		
22c. PHYSICIAN'S NAME (Type) DR. LEO H. LEY		22d. ADDRESS 456 N. CENTRE ST., CUMBERLAND, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 16, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		23d. LOCATION (City or Town) Cumberland, Alleg.		(County) Md.
24. FUNERAL DIRECTOR John J. Hafer, Jr.		ADDRESS 230 Bellto Ave. Cumberland		25a. REC'D BY REGISTRAR DEC 19 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

10301

10302

ACCESSION

NUMBER

Y

CHARGE DATE

TO CIRC.

CIRCULAR

ITEMS ISSUED

ITEMS ISSUED

DECEDENCE

OWNER

33436410

X

SURNAME

LAST NAME

A.2.0

GENERAL INFORMATION

EXPIRATION DATE

1970-02-28

1970-02-28

1970-02-28

ITEMS ISSUED

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16425

CERTIFICATE OF DEATH

16424

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)	
Allegany Maryland		a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b Life	
c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 217 Washington St		d. STREET ADDRESS 217 Washington St	
3. NAME OF DECEASED (Type or print) Emma		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
First		Middle	
Last		4. DATE OF DEATH Dec. 6 1966	
5. SEX F		6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 6/24/84	
WIOOWEO <input checked="" type="checkbox"/>		9. AGE (In years last birthday) 82 yrs. 10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (County & State, or foreign country) Cumberland Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nicholas Zihlman		14. MOTHER'S MAIDEN NAME Julia Etzel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Miss Louise Zihlman Cumb. Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal cardiac failure 443X OUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic and hypertensive cardiovascular disease. (c) Generalized arteriosclerosis.			
INTERVAL BETWEEN ONSET AND DEATH Immediate			
11 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 18 July 1955, to 6 December 1966, that (I) (we) last saw the deceased alive on 5 December 1966, and that death occurred at 10:30 AM the causes and on the date stated above.			
22a. SIGNATURE W. Alfred Van Ormer		22b. DATE SIGNED 7 December 1966	
22c. PHYSICIAN'S NAME (Type) W. Alfred Van Ormer, M.D.		22d. ADDRESS Medical Bldg., Cumberland, Md. 21502	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF 12/9/66	
23c. NAME OF CEMETERY OR CREMATOR Y Rose Hill Cem.		23d. LOCATION (City, town or county) (State) Cumberland Md	
24. FUNERAL DIRECTOR Louis Stein Inc. Cumb. Md.		25a. REC'D BY REGISTRAR Charles Judge 25b. REGISTRAR'S SIGNATURE	
ADDRESS		DATE DEC 12 1966	

STYLUS ONBOARD INSTRUMENT

-UNCOOLED SPECTROGRAPHIC SIGHTLINE CRYSTAL

REFLECTIONS FROM THE CRYSTAL

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16426

CERTIFICATE OF DEATH

16425

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY C Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 11/8/55	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Flossie Middle Ellen Last Fazenbaker		4. DATE OF DEATH December 17, 1966	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 6/24/1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9. AGE (In years last birthday) 67 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY Firm Rock, Maryland		11. BIRTHPLACE (County & State, or foreign country) Firm Rock, Maryland	
13. FATHER'S NAME Ezra Michael		12. CITIZEN OF WHAT COUNTRY U.S. A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT P. O. Box 599, Allegany County Infirmary records		Address Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① Multiple Sclerosis 345-X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ② Vices Gaffeyay DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 11/8/1955, 19, to 12/17/66, 19, that (I) (we) last saw the deceased alive on 12/17/66 19, and that death occurred at P. M., fram causes and an the date stated above.		at 1:45 P. M.	
22a. SIGNATURE Lee B. Mathews, M. D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 12/18/1966
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify Burial)		23b. DATE THEREOF Dec 20, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL Philos Cem.		23d. LOCATION (City or Town) (County) (State) Westport Alle. Md.	
24. FUNERAL DIRECTOR Ed Boral Westernport, Md.		25a. ADDRESS	25b. REC'D BY REGISTRAR DEC 28 1966
		25c. DATE	26b. REGISTRAR'S SIGNATURE Charles Judge

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REFERENCES

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16427

CERTIFICATE OF DEATH

16426

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.****10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial/transit, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 4 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 1602 HOLLAND ST.	
e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
3. NAME OF DECEASED (Type or print)	First DORA	Middle O	Last FISHER
4. DATE OF DEATH	Month DEC.	Day 25	Year 19 66
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH MAY 6, 1894		9. AGE (In years at birthday) 72 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) FROSTBURG, MD.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME JOHN BOND		14. MOTHER'S MAIDEN NAME ANNA RICE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> NO		16. SOCIAL SECURITY NO. 211 05 5201	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3.31.66	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus Pulmonary Fibrosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12.21.1966 to 12.25.1966 , that (I) last saw the deceased alive on 12.24.1966 , and that death occurred at 4 PM . Main causes and all the date stated above.		22b. DATE SIGNED 12.27.66	
22a. SIGNATURE W. F. Williams		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS		22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC. 28, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL ROSE HILL CEMETERY		23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.	
24. FUNERAL DIRECTOR BYRON KIGHT		ADDRESS CUMBERLAND, MD.	
		25a. REC'D BY REGISTRAR DATE DEC. 30 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16428

16427

1. PLACE OF DEATH a. COUNTY Allegany		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland					
3. NAME OF DECEASED (Type or print) Truman		First C.	Middle a.	Last Fuller	4. DATE OF DEATH Month 12	Month 12	Day 2	Year 1966	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. OATE OF BIRTH 5/8/97	9. AGE (In years last birthday) 69 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0	12. IF UNDER 24 HRS. Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY B&O RR		11. BIRTHPLACE (County & State, or foreign country) Cumberland Md U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME (D) Clifton Fuller		14. MOTHER'S MAIDEN NAME (D) Mary Lou Wright							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWT		17. INFORMANT Address patient's chart					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular thrombosis DUE TO Hypertension &clerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 443X DUE TO hypertension &clerosis (c) year									
INTERVAL BETWEEN ONSET AND DEATH 1 week									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 1958 , to Dec 3, 1966 that (I) (we) last saw the deceased alive on Nov 1 1966 , and that death occurred at M , from the causes and on the date stated above.									
22a. SIGNATURE J. M. Shindler		22b. DATE SIGNED 12/3/68							
22c. PHYSICIAN'S NAME (Type) Louis Stein Inc.		M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Cumberland Md							
23a. BURIAL, CREMATION, REMOVAL, (Specify) Burial		23b. DATE THEREOF 12/5/66		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Rose Hill Cem. Cumb. Md.		23d. LOCATION (City, town or county) (State) Cumberland Md			
24. FUNERAL DIRECTOR Louis Stein Inc.		25a. REC'D BY REGISTRAR DATE DEC 7 1966		25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16429

CERTIFICATE OF DEATH

16428

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE ALLEGANY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 28 DAYS				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) MADELYN		First MADELYN	Middle N			
4. DATE OF DEATH DEC. 22 1966		5. SEX FEMALE	6. COLOR OR RACE WHITE			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH JULY 23, 1900				
9. AGE (in years last birthday) 66 yrs.		10. KIND OF BUSINESS OR INDUSTRY Retail Store	11. BIRTHPLACE (County & State, or foreign country) KITTANNING, PA.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ROBERT H. PAINTER				
14. MOTHER'S MAIDEN NAME LUELLA M. WALTERS		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				
16. SOCIAL SECURITY NO. 099-14-3161		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. aspirites		INTERVAL BETWEEN ONSET AND DEATH				
(b) DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ASND. is myocardial insufficiency failure						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hillcrest Burial Park	20f. (City or town) Cumberland	(County) Allegany	(State)
21. I certify that (I) (this hospital) attended the deceased from 11-24 1966 to 12-22 1966 that (I) (we) lost saw the deceased alive on 12-22 1966 , and that death occurred 12-24 1966 A.M. from causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
22a. SIGNATURE William P. James		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22b. DATE SIGNED 12-24-66			
22c. PHYSICIAN'S NAME (Type) Dr. William P. James		22d. ADDRESS 441 N. Centre St. Cumberland, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 24, 1966	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Hillcrest Burial Park	23d. LOCATION (City or Town) Cumberland, Md.	(County) Allegany	(State)
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. RECD BY REGISTRAR JAN 3 1967		25b. REGISTRAR'S SIGNATURE John J. Scarpelli		
VR A15 (4) 20 M 1/66						

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

16430

CERTIFICATE OF DEATH

16429

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland Allegany Garrett				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frostburg Years		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg 01-1				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 58 Frost Avenue		d. STREET ADDRESS Star Route				
3. NAME OF DECEASED (Type or print)	First John	Middle Jacob	4. DATE OF DEATH Month Day Year Hafer, Sr. December 28 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Month Day Year Nov. 14, 1905 61 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Funeral Home Owner		10b. KIND OF BUSINESS OR INDUSTRY Self				
11. BIRTHPLACE (County & State, or foreign country) Allegany Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Jacob Hafer		14. MOTHER'S MAIDEN NAME Annie Trescher				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-10-4485				
17. INFORMANT John J. Hafer, Jr., 230 Balto Ave, Cumberland		Address Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Tumor, glioma, diffuse INTERVAL BETWEEN ONSET AND DEATH 237X Nov. 66						
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> Not White at work <input type="checkbox"/> p.m. 19		20d. INJURY OCCURRED <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) factory, street, office bldg., etc.	20f. (City or town) Cumberland	(County) Md.	(State) Md.
21. I certify that (I) (this hospital) attended the deceased from 1 Nov. 1966 , to 28 Dec. 1966 , that (I) (we) last saw the deceased alive on 27 Dec. 1966 , and that death occurred at 8 AM , from the causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
22a. SIGNATURE W. Alfred Van Ormer		22b. DATE SIGNED Dec. 31, 1966				
22c. PHYSICIAN'S NAME (Type) W. Alfred Van Ormer		22d. ADDRESS 122 S. Centre Street, Cumberland, Md				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 2, 1967	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Hillcrest Burial Park	23d. LOCATION (City, town or county) (State) Near Cumberland, Md.		
24. FUNERAL DIRECTOR John J. Hafer, Jr.		ADDRESS John J. Hafer, Jr., 230 Balto Ave., Cumberland		25a. REC'D BY REGISTRAR JAN 4 1967	25b. REGISTRAR'S SIGNATURE Charles Judge	
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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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16431

CERTIFICATE OF DEATH

16430

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be reigned by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE PA.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYNDMAN, PA.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYNDMAN, PA.	
c. LENGTH OF STAY IN lb 2½ HRS.		d. STREET ADDRESS 44 CLARENCE ST.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HUGO L. HAGGENMILLER		First HUGO	Middle L.
3. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-8-1904
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY MUNICH, GERMANY	
11. BIRTHPLACE (County & State, or foreign country) MUNICH, GERMANY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LUDWIG HAGGENMILLER		14. MOTHER'S MAIDEN NAME KATHRYN SCHNEIDER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 091-24-7499	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, esp. rt. lung		INTERVAL BETWEEN ONSET AND DEATH 1 year	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma rt. bronchus		DUE TO 2 1/2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Memorial Hospital
20f. (City or town) CUMBERLAND		(County) (State) MARYLAND	
21. I certify that (I) (this hospital) attended the deceased from 3 Nov 1966 to 15 Dec 1966 , that (I) (we) last saw the deceased alive on 15 Dec 1966 , and that death occurred 2:05 PM , from causes and on the date stated above.			
22a. SIGNATURE W. Alfred Van Ormer		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 16 Dec 66
22c. PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER		22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD	
23a. BURIAL, CREMATION, BURIAL (Specify) BURIAL		23b. DATE THEREOF Dec. 18, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Lybarger Cemetery
23d. LOCATION (City or Town) Buffalo Mills, Pa.		(County) (State) PENNSYLVANIA	
24. FUNERAL DIRECTOR Alfred H. Ziegler		ADDRESS Hyndman, Pennsylvania	25a. RECD BY REGISTRAR DATE DEC 21 1966
			25b. REGISTRAR'S SIGNATURE Judge

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
16432				16431											
1. PLACE OF DEATH a. COUNTY Allegany				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b DOA											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Miner's Hospital				e. STREET ADDRESS R.D. # 4											
3. NAME OF DECEASED (Type or print) Janet A Hampe				First		Middle		Last		4. DATE OF DEATH	Month	Day	Year		
5. SEX		6. COLOR OR RACE		7. MARRIED		NEVER MARRIED		8. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.			
Female		White		<input type="checkbox"/> WIDOWED		<input type="checkbox"/> DIVORCED		Sept 15, 1951		15 yrs.	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Student				10b. KIND OF BUSINESS OR INDUSTRY Meyersdale, Pa.											
13. FATHER'S NAME Clyde Hampe				11. BIRTHPLACE (State or foreign country) Clyde Hampe R.D. # 4 Meyersdale, Pa.											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. Lydia Baker											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)				17. INFORMANT Address											
816.4				DUE TO Shock											
Conditions, If any, which gave rise to Immediate cause (e), stating the underlying cause last.				Ruptured Liver; Contusions of Lungs											
(b)															
DUE TO				Fractures of both Femurs											
(c)				(Automobile Accident)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)															
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) Passenger in a two car collision								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour am. 1:30 p.m. Dec. 28 1966				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work								20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. #40 7 Miles East Grantsville, Garrett, Maryland			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
Benedict Skitarelic ACTUAL SIGNATURE															
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Jan 1, 1967 Greenville Cemetery				23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Meyersdale, Pa.				23d. LOCATION (City, town or county) (State) Meyersdale R.D. # 3 Pa.			
24. FUNERAL DIRECTOR John Doe Inc.				25a. REC'D BY REGISTRAR JAN 3 1967								25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 8 9 Film G385 2/6/67 mh

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16432

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

16433

PLACE OF DEATH

a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN lb

Minutes

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE

xxxxxxxxxx West Virginia-Mineral

b. COUNTY

West Virginia-Mineral

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Wiley Ford

85.3

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)First
MarshallMiddle
LeeLast
Hardy4. DATE
OF
DEATH

Dec. 22 1966

5. SEX

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED WIDOWED DIVORCED

B. DATE OF BIRTH

1928

9. AGE (In years
last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

Male

White

Jan. 4, 1927

39 30 yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Machinist-Carman

10b. KIND OF BUSINESS OR INDUSTRY

Railroad

11. BIRTHPLACE (State or foreign country)

Wiley Ford, W. Va.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Ralph Hardy

14. MOTHER'S MAIDEN NAME

Betie ??

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

yes

Korean

16. SOCIAL SECURITY NO.

234-38-8417

17. INFORMANT

Mrs. Wanda Hardy, Wiley Ford, W. Va. Wife

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

420.1

Coronary Thrombosis

INTERVAL BETWEEN
ONSET AND DEATH

Sudden

DUE TO

Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last.

(b)

DUE TO

(c)

Coronary Sclerosis

--

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 1920d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Name, farm,
factory, street, office bldg, etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion
death resulted from: Nutrol causes , Accident , Suicide , Homicide , Undetermined manner ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER

22. DATE SIGNED

December 22, 1966

Cumberland, Md.

Address (Street, city, town, or county)

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE THEREOF

Dec. 26, 1966

23c. NAME OF CEMETERY OR CREMATORIAL

Sunset Memorial Park

23d. LOCATION (City or Town) (County) (State)

Cumberland, Md. Allegany

24. FUNERAL DIRECTOR

James F. Scarpelli, Cumberland, Md.

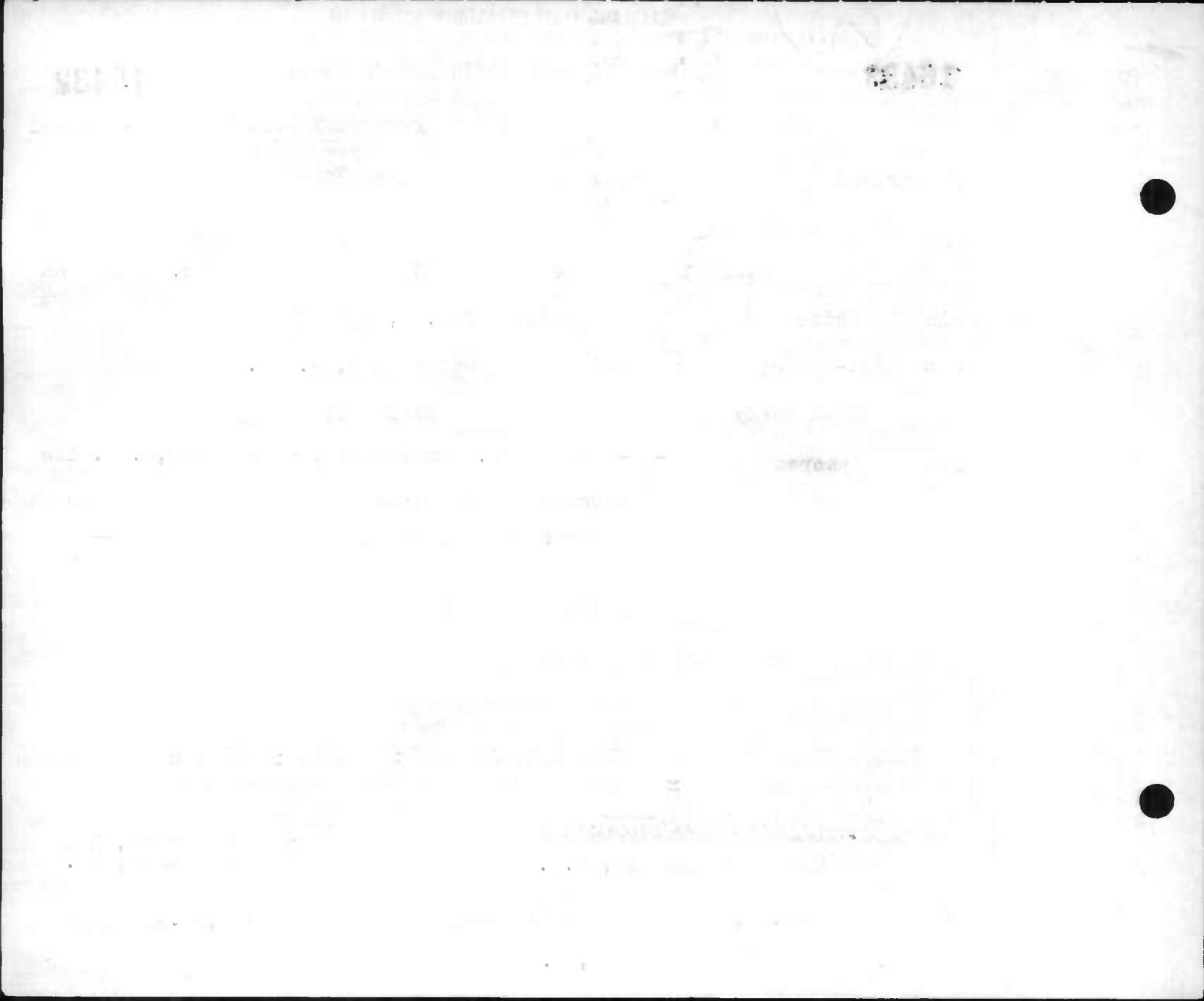
ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE JAN 3

1967 Charles Judge



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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16433

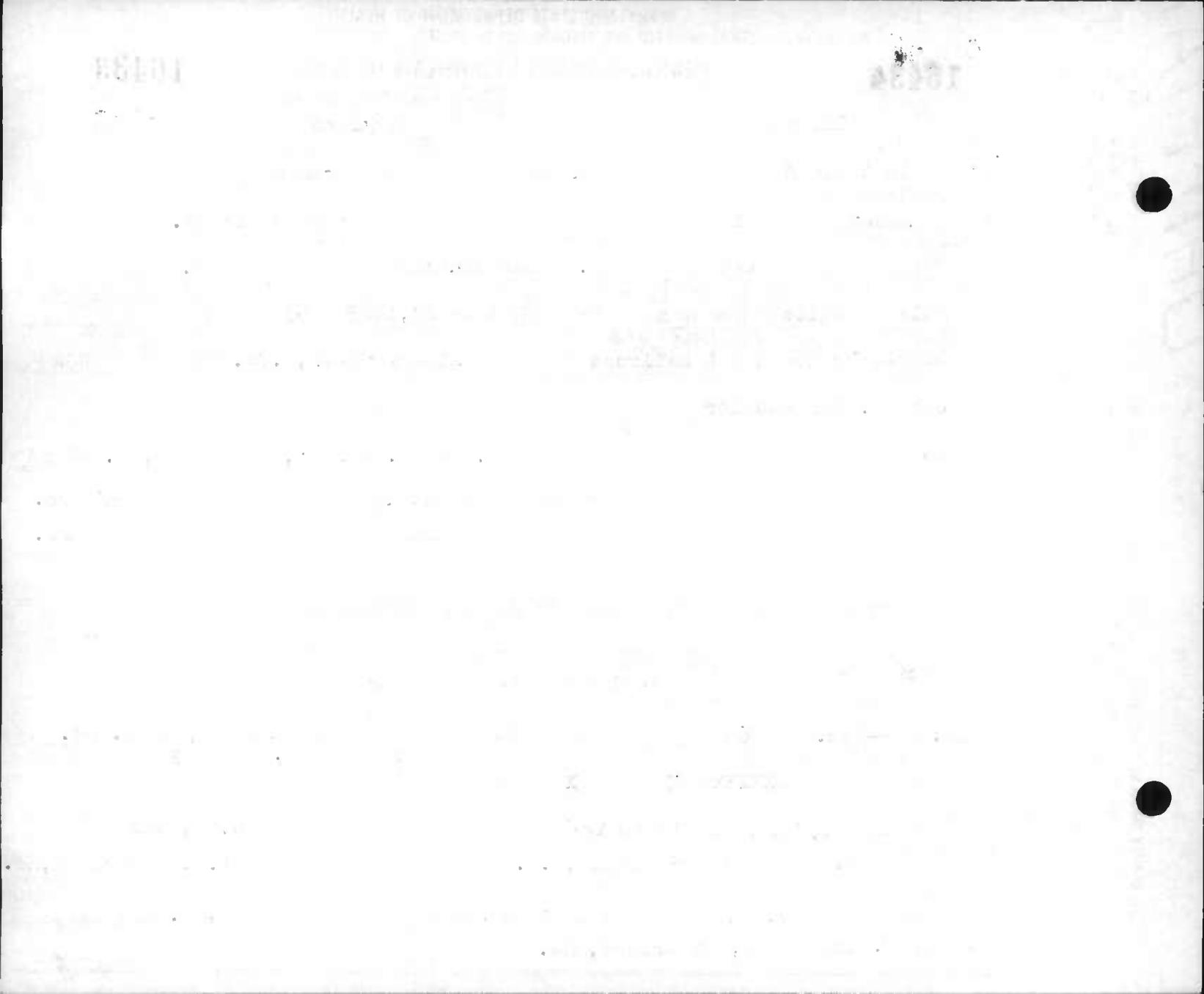
**FOR STATE
HEALTH DEPT.**

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16434

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 50 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS 126 Springdale St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First John	Middle E.	Last Hasenbuhler
4. DATE OF DEATH	Month Dec.	Day 27	Year 19 66
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
B. DATE OF BIRTH June 18, 1883	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Brakeman	10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) Sleepy Creek, W.Va.	
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John A. Hasenbuhler	14. MOTHER'S MAIDEN NAME Amie ??		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Eva A. Fuller, Cumberland, Md. Friend	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		Subdural Hemorrhage	INTERVAL BETWEEN ONSET AND DEATH 4½ hrs.
		Skull Fracture	4½ Hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH:	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down steps at home		
20c. TIME OF INJURY Month, Day, Year Hour o.m. 11:50 pm Dec. 27 1966	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Cumberland, Alleg. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: XXXXXX Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Dec. 27, 1966 22. DATE SIGNED DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 31, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.	ADDRESS	25a. REC'D BY REGISTRAR DATE JAN 3 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



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1(M)FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16435

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16434

1. PLACE OF DEATH a. COUNTY Allegany		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 3 days		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) National R-F-D . Frostburg		f. STREET ADDRESS O.H.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) DONALD		First M	Middle HAWKINS	Last M	4. DATE OF DEATH 12/22/1966	Month 12	Dey 19	Year 1966	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/5/1905	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Frostburg, MD.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Alfred Hawkins		14. MOTHER'S MAIDEN NAME Clara Grove		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Grahamtown		17. INFORMANT Jack Hawkins	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 900.0		3 Days							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) } DUE TO } (c)		3 Days							
Contusions of Brain		3 Days							
(Fall down Steps)		3 Days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Fell down steps at home							
20c. TIME OF INJURY Month, Day, Year Hour e.m. 2:00 - Dec. 19 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) R.D.Frostburg, Alleg. Md.	(County) Cumberland, Md.	(State) MD.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.							
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/24/1966		22c. NAME OF CEMETERY OR CREMATORIAL Memorial Park		DATE SIGNED December 22, 1966			
23. FUNERAL DIRECTOR GEORGE EICHHORN		Address (Street, city, town, or county) Lonaconing, MD.							
VS. A15ME 5M 9/60		24a. REC'D BY REGISTRAR DEC 26 1966							
B		24b. REGISTRAR'S SIGNATURE <i>George Eichhorn</i>							

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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16436

CERTIFICATE OF DEATH

16435

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		e. STREET ADDRESS Rt. 1	
3. NAME OF DECEASED (Type or print) JULIA		First JULIA	Middle MAE
Last HITCHINS		4. DATE OF DEATH Month DECEMBER	
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH NOV. 22, 1913		9. AGE (In years last birthday) 53 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM V. BUSKIRK		14. MOTHER'S MAIDEN NAME LAURA CLISE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT JAMES S. HITCHINS, FROSTBURG, MD. RT. 1		Address BOX 141	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metastatic carcinoma</i> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) <i>Premier carcinoma at lung</i> last. } DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>6 mos.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Dec. 19, 1966</i> , to <i>Dec 22, 1966</i> , that (I) (we) last saw the deceased alive on <i>Dec 22, 1966</i> , and that death occurred at <i>1:15 P.M.</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>A. Paige Strong</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) A. PAIGE STRONG, M. D.		22d. ADDRESS 167 E. MAIN ST - FROSTBURG MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC. 24, 1966	23c. NAME OF CEMETERY OR CREMATORIAL FBG. MEMORIAL PARK
24. FUNERAL DIRECTOR ADDRESS JOSEPH R. DURST, SR., FROSTBURG, MD.		25a. REC'D BY REGISTRAR DATE DEC 27 1966	25b. REGISTRAR'S SIGNATURE <i>James J. Durst</i>

101

51



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

16437

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16436

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b DOA				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Hoff	First Blanche	Middle NMI	4. DATE OF DEATH Dec. 30 1966			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 5, 1900			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9. AGE (In years last birthday) 66 yrs.				
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) West Virginia				
13. FATHER'S NAME Samuel Crothers		12. CITIZEN OF WHAT COUNTRY? U S A				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Martin L. Hoff, Route 6, Cumberland, Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden				
Coronary Occlusion		Coronary Sclerosis				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Cumberland	(County) Allegany	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.			22. DATE SIGNED December 30, 1966		
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 2, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park	23d. LOCATION (City or Town) Near Cumberland, Allegany		
24. FUNERAL DIRECTOR John J. Hafer, Jr.		ADDRESS John J. Hafer, Jr., 230 Baltimore Ave. Cumberland	25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

16438

CERTIFICATE OF DEATH

Reg. Dist. No.

16437

1. PLACE OF DEATH a. COUNTY <i>Allegany</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Allegany</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumberland</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumberland</i>		d. STREET ADDRESS <i>13 N. Lee St.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>13 N. Lee St.</i>				d. STREET ADDRESS <i>13 N. Lee St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <i>Anthony</i>	Middle <i>Joseph</i>	Last <i>Houck</i>	4. DATE OF DEATH Dec. 7, 19 1966	Month	Day	Year
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5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/24/1894</i>	9. AGE (In years lost birthday) 71 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Maintenance Employee</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Queen City Dairy</i>	11. BIRTHPLACE (State or foreign country) <i>Cumberland, Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13. FATHER'S NAME <i>George M. Houck</i>	14. MOTHER'S MAIDEN NAME <i>Barbara Bigler</i>	Address
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i>	16. SOCIAL SECURITY NO. <i>214-07-2536</i>	17. INFORMANT <i>Mrs. Helen A. Houck</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
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PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Left ventricular failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Arteriosclerotic and coronary CVD</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>
(b) DUE TO <i>Emphysema</i>		4 years
(c)		

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Emphysema</i>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) <i>62 Greene St.</i>

21. I certify that I attended the deceased from <i>1 - 20</i> , 19 <i>62</i> , 12 - 7, 19 <i>66</i> , that I last saw the deceased alive on <i>12 - 6</i> , 19 <i>66</i> , and that death occurred at <i>12 p.m.</i> , from the causes and on the date stated above.
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ADDRESS (Street, city or town, state) <i>62 Greene St.</i>	DATE SIGNED <i>12-8-66</i>
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ACTUAL SIGNATURE <i>Ralph W. Ballin, M.D.</i>	PHYSICIAN'S NAME (Type) <i>Ralph W. Ballin, M.D.</i>	CUMBERLAND, MD. 21502
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22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12/12/66</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Michael's Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Frostburg, Allegany, Md.</i>
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23. FUNERAL DIRECTOR'S SIGNATURE <i>H. Wayne George</i>	ADDRESS <i>Cumberland, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>DEC 13 1966</i>	24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
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STATE OF HAWAII - DIVISION OF
DEPARTMENT OF HEALTH - SANITATION

DEKLICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

16439

CERTIFICATE OF DEATH

16438

1. PLACE OF DEATH o. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE PENNSYLVANIA		b. COUNTY SOMERSET		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 4HRS. 5 MIN.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MEYERSDALE		d. STREET ADDRESS RT. #4,		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS RT. #4,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First RANDY	Middle GENE	Last HUTZELL	4. DATE OF DEATH DECEMBER 5 1966	Month Dec	Day 5	Year 1966
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	X	8. DATE OF BIRTH 2-3-1966	9. AGE (In years lost birthday yrs.) 10	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MEYERSDALE, PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME KENNETH HUTZELL		14. MOTHER'S MAIDEN NAME EDITH TEDROW		Address MEMORIAL HOSPITAL - CUMBERLAND, MD.				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)								
16. SOCIAL SECURITY NO.								
17. INFORMANT								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 340.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Shock Sepsis Meningitis, H. Influenza								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR. CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from DEC 5 1966 to 19 19 , that (I) (we) last saw the deceased alive on 19 19 , and that death occurred at 3:25 P.M. from causes and on the date stated above.								
22a. SIGNATURE Robert D. Brodell		22b. DATE SIGNED 1966						
22c. PHYSICIAN'S NAME (Type) DR. ROBERT D. BRODELL		22d. ADDRESS 500 GREENE ST., CUMBERLAND, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-7-66		23c. NAME OF CEMETERY OR CREMATORIAL Union Cemetery		23d. LOCATION (City or Town) Meyersdale		
24. FUNERAL DIRECTOR S.P. Konkau, Meyersdale, Pa.		ADDRESS		23e. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge		
VR A15 (4) 20 M 1/66		DATE DEC 9 1966		DATE DEC 9 1966				

4501

HTA 10-30-2002-57

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32920

HTA 10-30-2002-57

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HTA 10-30-2002-57

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HTA 10-30-2002-57

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334620-57-3M

HTA 10-30-2002-57

4501

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

M 16440

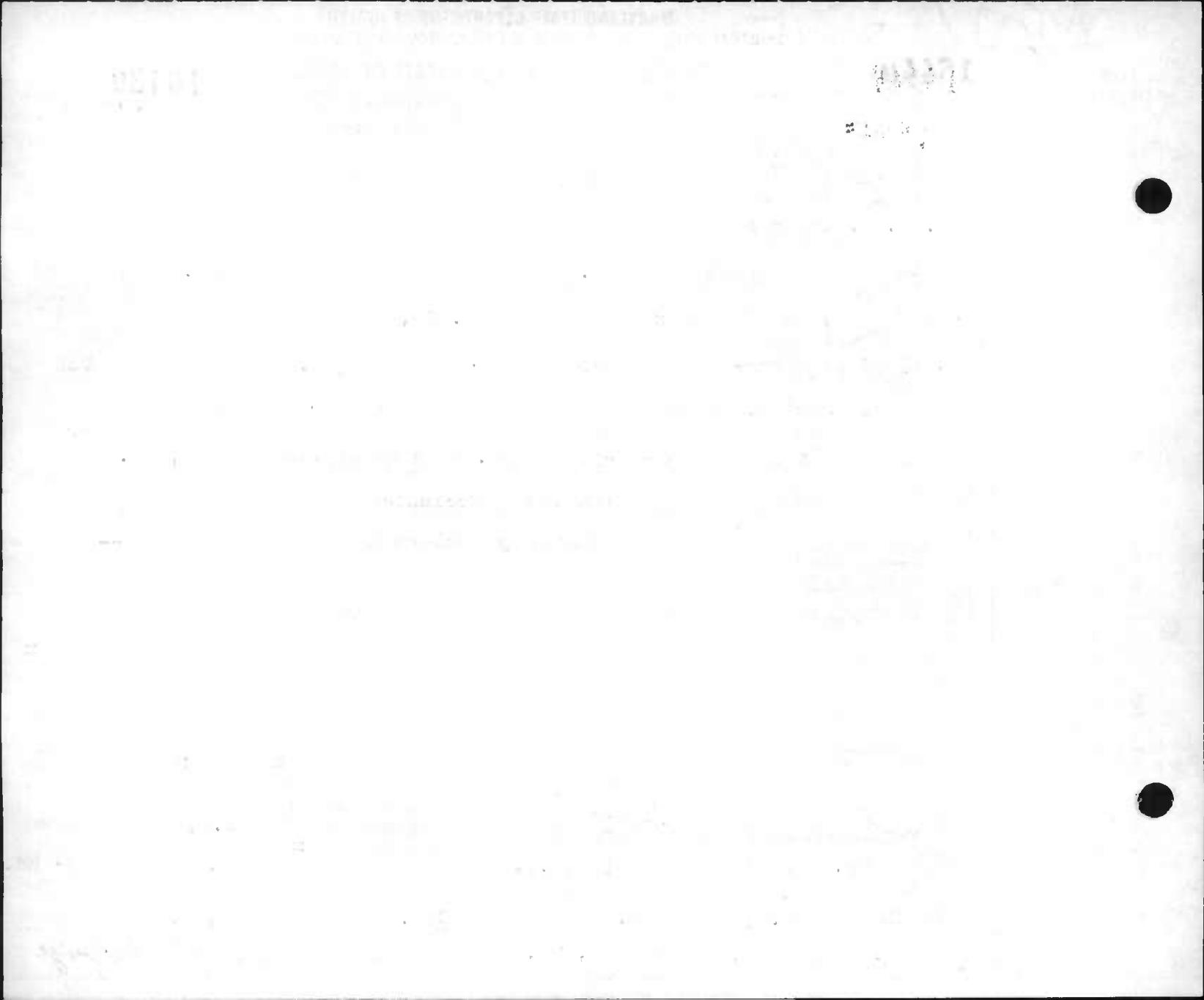
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16439

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Enter Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, within any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 75 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 204 Hay Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D. O. A. Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John F. Johnson		First John	Middle F.
4. DATE OF DEATH Dec. 4 1966	Month Dec.	Day 4	Year 1966
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Feb. 21, 1891		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Yard Foreman		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) Cumberland, Md.
13. FATHER'S NAME Benedict A. Johnson		14. MOTHER'S MAIDEN NAME Louise Dummel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 705-09-3505	17. INFORMANT Address Mrs. Rita Mowery, Cumberland, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		19. INTERVAL BETWEEN ONSET AND DEATH Sudden	
Coronary Occlusion			
Coronary Sclerosis		--	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Dec. 5, 1966 22. DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Rt. 9 Cumberland Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 7, 1966	23c. NAME OF CEMETERY OR CREMATORIUM SS. Peter & Paul Cem.
23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany		23e. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE DEC 9 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)					
a. COUNTY Allegany MARYLAND						a. STATE Maryland b. COUNTY Allegany					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, M.D.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital						d. STREET ADDRESS 426 Chestnut St.					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED First Cecilia Middle B. Jones Last			4. DATE OF DEATH December 9 1966								
5. SEX Female 6. COLOR OR RACE White			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 2-15-91			9. AGE (in years last birthday) 75 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Cumberland MD.			12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME John J. Becker			14. MOTHER'S MAIDEN NAME Mary Dickel								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <input checked="" type="checkbox"/> No <input type="checkbox"/> unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>None</i>			17. INFIRMITY Patient Chart			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH											
PART I. DEATH WAS CAUSED BY: 2 weeks											
IMMEDIATE CAUSE (a) Congestive Heart Failure											
5271 DUE TO 2 weeks											
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cor pulmonale											
(c) Emphysema 2 years											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED While Not While p.m. 19 at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 8 - 10 , 19 58 , to 12 - 9 , 19 66 , that (I) (we) last saw the deceased alive on 12 - 9 , 19 66 , and that death occurred at 9 p M, from the causes and on the date stated above.			22b. DATE SIGNED 12-10-66								
22a. SIGNATURE <i>Loyd B. Ballin</i>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>			M.O. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) Dr. B allin			22d. ADDRESS 62 Greene S. Cumbe rland, Md. 21502								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 12/13/66			23c. NAME OF CEMETERY OR CREMATOR Y St. Peter & Paul Cem.			23d. LOCATION (City, town or county) Cumberland, Md. (State)		
24. FUNERAL DIRECTOR <i>Lewis Stein Inc. Cumb. Md.</i>			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
						DATE DEC 14 1956					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16442

16441

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 46 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROSE (Guiliano)	First ROSE	Middle (Guiliano)	Last JULIANO
4. DATE OF DEATH DECEMBER 17 1966	Month DECEMBER	Day 17	Year 1966
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 22 1900
9. AGE (In years last birthday) 66 yrs.	10. KIND OF BUSINESS OR INDUSTRY Housewife Own Home	11. BIRTHPLACE (County & State, or foreign country) ITALY -MINTURNO	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Lawrence Lazerra	14. MOTHER'S MAIDEN NAME Philomenia ??	Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO.	17. INFORMANT	PT'S CHART
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Atherosclerosis DUE TO 5 yrs (c)			
INTERVAL BETWEEN ONSET AND DEATH 2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus with ergotherapy			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.) Injury occurred while at work	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 122 N SMALLWOOD STREET CUMBERLAND, MD.
20f. (City or town) CUMBERLAND	(County) MARYLAND	(State) MARYLAND	
21. I certify that (I) (this hospital) attended the deceased from July 1965 to Dec. 17 1966 , that (I) (we) last saw the deceased alive on Dec. 17 1966 , and that death occurred at 2 PM , from the causes and on the date stated above.			
22a. SIGNATURE DR. M. GLICK & SPIGGLE, M.D.		22b. DATE SIGNED 12-19-66	
22c. PHYSICIAN'S NAME (Type) DR. M. GLICK & SPIGGLE, M.D.	M.D. ATTENDING <input checked="" type="checkbox"/> ADDRESS 122 N SMALLWOOD STREET CUMBERLAND, MD.	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 21, 1966	23c. NAME OF CEMETERY OR CREMATORIAL St. Mary's Cemetery	23d. LOCATION (City, town or county) (State) Cumberland, Md. Allegany
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.	ADDRESS James F. Scarpelli, Cumberland, Md.	25a. REC'D BY REGISTRAR DEC 28 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

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wy 2

water track integrated
area beneath buried

Chegwa River outlet 14' elevation

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16443

CERTIFICATE OF DEATH

16442

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician's director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 11½ HRS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First MICHAEL	Middle SHANE	Last KELLY
4. DATE OF DEATH DECEMBER 27 1966	Month	Day	Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-27-66
9. AGE (In years last birthday) NEWBORN	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.
12. CITIZEN OF WHAT U.S. COUNT? A.	13. FATHER'S NAME MICHAEL D. KELLY		
14. MOTHER'S MAIDEN NAME CAROL A. MORGAN	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		
16. SOCIAL SECURITY NO.	17. INFORMANT MEMORIAL HOSPITAL CUMBERLAND, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prevalent</i> <i>776X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			Address INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
21. I certify that (I) (this hospital) attended the deceased from 9:35 AM 9:00 P.M. 12-27, 1966, that (I) (we) last saw the deceased alive on 19, and that death occurred at M, from causes and on the date stated above.		20f. (City or town) (County) (State)	
22c. PHYSICIAN'S NAME (Type) DR. OLIVER H. NADEAU		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 12-29-66
23a. CEMETAL CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 12-30-66	23c. NAME OF CEMETERY OR CREMATORIAL Memorial Hospital Cumberland Allegany, Md
24. FUNERAL DIRECTOR John A. Mohr		ADDRESS	23d. LOCATION (City or Town) (County) (State)
			25a. REC'D BY REGISTRAR DATE JAN 4 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16444

CERTIFICATE OF DEATH

16443

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gilmore Rural # 1 Frostburg, MD.		d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Mary L Kennedy		First	Middle	Last	4. DATE OF DEATH 12/8/1966	Month	Day	Year 19	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 3/30/1897		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Barton, MD.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Simon Nolan		14. MOTHER'S MAIDEN NAME Mary Ellen Carr							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Eugene Patrick Merrbaugh, Gilmore, MD.		Address (SON)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33IX		DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause Arteriosclerosis generalized		INTERVAL BETWEEN ONSET AND DEATH 6 hrs					
(b) DUE TO lost.		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) LONACONING		(County) MD.	
21. I certify that (I) (this hospital) attended the deceased from 1959 , to Dec 8 1966 , that (I) (we) last saw the deceased alive on Dec 8 1966 , and that death occurred at 33 M. from causes and on the date stated above.									
22a. SIGNATURE L.R. MILES, JR. M.D.		M.D. ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12-8-66	
22c. PHYSICIAN'S NAME (Type) L.R. MILES, JR. M.D.		22d. ADDRESS LONACONING MD							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/10/1966		23c. NAME OF CEMETERY OR CREMATORIAL Laurel Hill Cemetery		23d. LOCATION (City or Town) Moscow, MD.		(County) MD.	
24. FUNERAL DIRECTOR GEORGE EICHORN		ADDRESS Lonaconing, MD.		25a. REC'D BY REGISTRAR DEC 12 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16445

CERTIFICATE OF DEATH

16444

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1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG	c. LENGTH OF STAY IN lb 4 HRS.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ECKHART	d. STREET ADDRESS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) FRANCIS JOSEPH	First	Middle	Last KOMATZ		
4. DATE OF DEATH Dec 6 1966	Month	Day	Year		
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/10/03	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINER		10b. KIND OF BUSINESS OR INDUSTRY COAL	11. BIRTHPLACE (County & State, or foreign country) ALLEGANY, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ANTHONY KOMATZ		14. MOTHER'S MAIDEN NAME MARTHA BOLLINGER		Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-01-3742	17. INFORMANT Mrs. ALBERT GERDEMAN, BATO., MD.	INTERVAL BETWEEN ONSET AND DEATH 2 days	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X		uramia			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		Chronic glomerulonephritis yrs. Complete kidney shutdown 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/4 1966, to 12/6 1966, that (I) (we) last saw the deceased alive on 12/6 1966 and that death occurred at 5 PM, from causes and on the date stated above.					
22a. SIGNATURE John B. Davis, M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 12/7/66
22c. PHYSICIAN'S NAME (Type) John B. Davis, M.D.		22d. ADDRESS Frostburg, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/9/66	23c. NAME OF CEMETERY OR CREMATORIAL ST. MICHAEL'S	23d. LOCATION (City or Town) (County) (State) FROSTBURG, ALLEG. MD.	
24. FUNERAL DIRECTOR HARVEY H. ZEIGLER HYNDMAN, PENNA.		ADDRESS		25a. RECD BY REGISTRAR DEC 12 1966	25b. REGISTRAR'S SIGNATURE g. Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16446

CERTIFICATE OF DEATH

16445

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
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1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE PENNSYLVANIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 38 DAYS		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYNDMAN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM		First M.	Middle KOOSER	4. DATE OF DEATH 12-2 1966	Month Day Year
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21, 6-17-1897	9. AGE (In years last birthday) 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist		10b. KIND OF BUSINESS OR INDUSTRY Pharmacy		11. BIRTHPLACE (County & State, or foreign country) MANOR, PA.	
13. FATHER'S NAME HERMAN W. KOOSER		14. MOTHER'S MAIDEN NAME SUSAN JOHNSON		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 190-05-9171		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Ca INTERVAL BETWEEN ONSET AND DEATH 1 yr.					
154X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Adeno - Ca of Rectum 2-3 yr.					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Hyndman (County) Bedford Co. (State) Paa	
21. I certify that (I) (this hospital) attended the deceased from 1964 , to 12-2, 1966 , that (I) (we) last saw the deceased alive on 12-2 1966 , and that death occurred at 6AM , from causes and on the date stated above.					
22a. SIGNATURE <i>A. J. Mirkin</i>		22b. DATE SIGNED 12-2 1966			
22c. PHYSICIAN'S NAME (Type) DR. A. J. MIRKIN		22d. ADDRESS 115 S. CENTRE ST.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF December 4, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Hyndman Cemetery	23d. LOCATION (City or Town) Hyndman (County) Bedford Co. (State) Paa	
24. FUNERAL DIRECTOR Harvey H. Zeegler		ADDRESS Hyndman, PA.		25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE
				DATE DEC 7 1966	

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16447

CERTIFICATE OF DEATH

16446

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 21 DAYS		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 311 GREENE STREET					
3. NAME OF DECEASED (Type or print) ANNA		First		Middle		Lost		4. DATE OF DEATH DECEMBER 5 1966	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-29-1876		9. AGE (In years last birthday) 90 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Employee of the Welfare Board.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME ANDREW KRAFT		14. MOTHER'S MAIDEN NAME SARA GUTHMAN							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-6864		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastric Sclerosis P.V.D 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Generalized Arteriosclerosis stating the underlying cause (c) most marked cerebrally								INTERVAL BETWEEN ONSET AND DEATH Since 8-29-65	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) CUMBERLAND (County) ALLEGANY (State)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.									
21. I certify that (I) (this hospital) attended the deceased from 8-29-65 to 12-5-66 , that (I) (we) last saw the deceased alive on 12-5-66 and that death occurred at 3:35 P.M. from causes and on the date stated above.								22b. DATE SIGNED 12-5-66	
22a. SIGNATURE R. F. Williams		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS 500 GREENE ST. CUMBERLAND, MD.					
22c. PHYSICIAN'S NAME (Type) DR. R. FEDDIS									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/7/66		23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland			
24. FUNERAL DIRECTOR H. Lee Silcox		ADDRESS Cumberland Maryland 21502		25a. REC'D BY REGISTRAR DEC 8 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16447

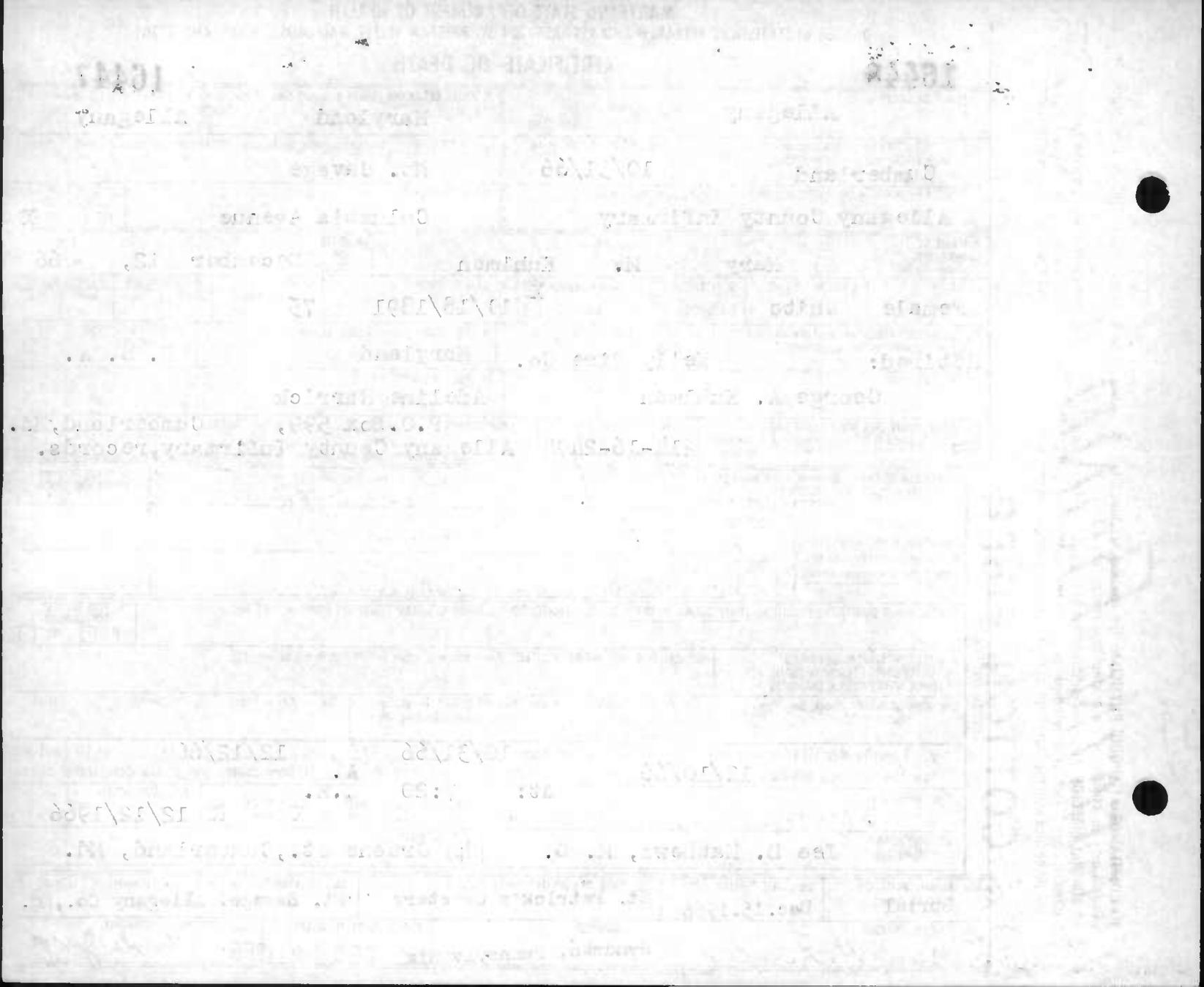
16448

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 10/31/66	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		d. STREET ADDRESS Columbia Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Mary	Middle M.	Last Kuhlman
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> X	B. DATE OF BIRTH 11/18/1891
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) yrs. 75
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired:		10b. KIND OF BUSINESS OR INDUSTRY Kelly Tire Co.	
13. FATHER'S NAME George A. Kuhlman		14. MOTHER'S MAIDEN NAME Adeline Rerrick	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16. SOCIAL SECURITY NO. 214-16-2494	
17. INFORMANT P.O. Box 599, Allegany County Infirmary records.		Address Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per-line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyperarteritis, char. degenerativa</u> <u>260X</u> Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) <u>Arteriosclerosis -</u> (c) <u>Diabetes Mellitus</u> (d) <u>Angina pectoris</u>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL/DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> At work <input type="checkbox"/> Not While <input type="checkbox"/> At work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10/31/66, 19, to 12/12/66, 19, that (I) (we) last saw the deceased alive on 12/10/66, 19, and that death occurred at A. M., from causes and on the date stated above. at: 7:20 A.M.			
22a. SIGNATURE <u>Lee B. Mathews, M.D.</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Lee B. Mathews, M. D.		22d. DATE SIGNED 12/12/1966	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 15, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL St. Patrick's Cemetery		23d. LOCATION (City or Town) (County) (State) Mt. Savage, Allegany Co., Md.	
24. FUNERAL DIRECTOR <u>Howard N. Feigler</u>		ADDRESS Hyndman, Pennsylvania	
25a. REC'D BY REGISTRAR DEC 15 1966		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16449

CERTIFICATE OF DEATH

16448

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b 50 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		d. STREET ADDRESS 75 WASHINGTON STREET	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First GWEN	Middle KYLE	Last	4. DATE OF DEATH DECEMBER 11, 1966	Month	Day	Year
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 16, 1884	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months 82	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) WALES		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS HARRIS				14. MOTHER'S MAIDEN NAME RUTH WILLIAMS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. NONE		17. INFORMANT GEORGE KYLE, WASHINGTON ST., FROSTBURG, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (g), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO arterio - Sclerotic Cardio - vascular disease INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Hypertension _____ stating the underlying cause (c) Rheumatoid arthritis major joints _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senility							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-21, 1966 , to 12-11, 1966 , that (I) (we) last saw the deceased alive on 12-10, 1966 , and that death occurred at 6:30 P.M. from causes and on the date stated above.							
22o. SIGNATURE H. C. Diehl		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/12/66			
22c. PHYSICIAN'S NAME (Type) H. C. DIEHL, M. D.		22d. ADDRESS 39 W. MAIN ST., FROSTBURG, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC. 14 '66		23c. NAME OF CEMETERY OR CREMATORIAL FBG. MEMORIAL PARK		23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.	
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge	
				DATE DEC 16 1966			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16450

Item 8 Film G384 1/3/67 mh

CERTIFICATE OF DEATH

16449

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	c. LENGTH OF STAY IN 1b 39 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 13 G. JANE FRAZIER VILLAGE			
e. IS RESIDENCE ON A FARM? NO					
3. NAME OF DECEASED (Type or print)	First EVA	Middle IDEELLA	Last LANGLEY		
4. DATE OF DEATH DECEMBER 18 1966	Month Day Year				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 1900 1-20-01		
9. AGE (In years last birthday) 66 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) MARYLAND - Cumberland			
12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME BIERMAN, DAVID (Beiderman)	14. MOTHER'S MAIDEN NAME KERNS, NORA				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. 218-24-8315	17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 194X DUE TO Cancerous thyroid			INTERVAL BETWEEN ONSET AND DEATH 6 mos		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), stating the underlying cause (c)	(b)	(c)	DUE TO		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized arteriosclerosis, Diabetes mellitus					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Nov 17 8:00 p.m. 12-18, 1966	(County) M.	(State) 1966
21. I certify that (I) (this hospital) attended the deceased from Nov 17 8:00 p.m. 12-18, 1966 , thot (I) (we) lost saw the deceased alive on 12-18 1966 , and thot death occurred of M. from causes and on the date stated above.	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
22a. SIGNATURE William P. James	M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 12-20-66
22c. PHYSICIAN'S NAME (Type) DR. WILLIAM P. JAMES	22d. ADDRESS 948 BEDFORD ST. CUMBERLAND, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 21, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Davis Memorial Park	23d. LOCATION (City or Town) Cumberland, Md.	(County) Allegany	(State)
24. FUNERAL DIRECTOR James F. Scarpelli, -Cumberland, Md.	ADDRESS	25a. REC'D BY REGISTRAR DEC 28 1966	25b. REGISTRAR'S SIGNATURE Charles George		
VR A15 (4) 20 M 1/66		DATE			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16451

CERTIFICATE OF DEATH

16450

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG	c. LENGTH OF STAY IN lb 29 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		d. STREET ADDRESS 94 FROST VILLAGE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First CATHERINE	Middle M.	4. DATE OF DEATH DECEMBER 31, 1966
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH AUG. 21, 1883
9. NEVER MARRIED <input type="checkbox"/>	10. DIVORCED <input type="checkbox"/>	11. AGE (In years lost birthday) 83 yrs.	12. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME LEWIS LONG	14. MOTHER'S MAIDEN NAME CORNELIA BURGESS	Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 111-55-3222	17. INFORMANT RAYMOND LAYMAN, RT. 1, FROSTBURG, MD.	18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 331X DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. Sensitivity		INTERVAL BETWEEN ONSET AND DEATH 12-2-66	
(b) DUE TO Hypertension, arterio-Sclerosis		—	
(c) DUE TO Esophageal Hernia		—	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Sensitivity			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12-2-66 , to 12-31-66 , that (I) (we) last saw the deceased alive on 12-31-66 , and that death occurred at 10:35 AM , from causes and on the date stated above.			
22a. SIGNATURE H. C. Diehl	M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 11/3/67	
22c. PHYSICIAN'S NAME (Type) H. C. DIEHL, M. D.	22d. ADDRESS 39 W. MAIN ST., FROSTBURG, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF JAN. 3, 1967	23c. NAME OF CEMETERY OR CREMATORIAL PARK FBG. MEMORIAL PARK	23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.	ADDRESS	25a. REC'D BY REGISTRAR DATE JAN 5 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16452

CERTIFICATE OF DEATH

16451

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 4 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 707 PRINCETON ST.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) EUGENE		First	Middle M.	Lost	4. DATE OF DEATH DECEMBER 13 1966	Month	Doy	Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 22, 1905	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. DAYS 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman - Driver		10b. KIND OF BUSINESS OR INDUSTRY Ice Cream Co.		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME ROBERT G. LEASURE				14. MOTHER'S MAIDEN NAME MELITHA ROBINETTE				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 214-05-8894		17. INFORMANT		Address MEMORIAL HOSPITAL, CUMBERLAND, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Myocardial Dystrophy (Thyroid)</i>				INTERVAL BETWEEN ONSET AND DEATH 4 days		
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		<i>Arteriosclerotic Heart Disease</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Anerysm of Thoracic Aorta</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from _____, to _____, that (I) (we) last saw the deceased alive on _____, and that death occurred at _____ from causes and on the date stated above.								
22a. SIGNATURE <i>Leasure</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>12/10/66</i>		
22c. PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN		22d. ADDRESS 59 GREENE ST., CUMBERLAND, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 16, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md.		
24. FUNERAL DIRECTOR Byron Kight		ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DEC 21 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician. Page 4 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16453

CERTIFICATE OF DEATH

16452

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 32 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 113 FREDERICK ST.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ROBERT	Middle J.	4. DATE OF DEATH DECEMBER 30 1966
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-21-1910
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATCHMAN		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.	
13. FATHER'S NAME WILLIAM H. LECHLITER		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 219-03-8257	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) CARCINOMA OF LUNG - Recurrent (9 MOS.?)		INTERVAL BETWEEN ONSET AND DEATH	
163X Conditions, if any, which gave rise to immediate cause (o). stating the underlying cause lost. (b) (c)		DUE TO DUE TO DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Previous Pneumonectomy (April 1966)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from MARCH 1966 to 12-30-66 , that (I) (we) last saw the deceased alive on 12-30-66 , and that death occurred at 6:20 PM , from causes and on the date stated above.			
22a. SIGNATURE THOMAS F. LUSBY M.D.		22b. DATE SIGNED 1/31/66	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 932 NATIONAL HWY., LA VALE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 2, 1967	
23c. NAME OF CEMETERY OR CREMATORIALy Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS	
		25a. REC'D BY REGISTRAR DATE JAN 6 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16454

CERTIFICATE OF DEATH

16453

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 4 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. STREET ADDRESS 477 GOETHE ST.	
3. NAME OF DECEASED (Type or print) EMMA		First B	Middle LINN
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 6-3-79		9. AGE (In years last birthday) 87 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) [REDACTED] Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James BROWN		14. MOTHER'S MAIDEN NAME E. CATHERINE RINKER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis DUE TO 181.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerosis (b) DUE TO 5 yrs (c) DUE TO Paroxysm of urinary Bladder 6 wks			
INTERVAL BETWEEN ONSET AND DEATH 3 mons			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) CUMBERLAND (County) MARYLAND (State) MD			
21. I certify that (I) (this hospital) attended the deceased from Aug 1966 to Dec 26 1966 , that (I) (we) last saw the deceased alive on Dec 26 1966 and that death occurred at 20P M, from causes and on the date stated above.			
22a. SIGNATURE Clay E. Durrett		22b. DATE SIGNED 12/27/66	
22c. PHYSICIAN'S NAME (Type) DR. CLAY E. DURRETT		22d. ADDRESS 236 VIRGINIA AVE., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/29/66	23c. NAME OF CEMETERY OR GREMATORIUM Rose Hill Cem.
24. FUNERAL DIRECTOR James Stein Inc. Cumb. Md.		23d. LOCATION (City or Town) (County) (State) Cumberland MD.	
ADDRESS		25a. REC'D. BY REGISTRAR DEC 28 1966	25b. REGISTRAR'S SIGNATURE James E. Durrett

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any part of it is necessary, write the word "pending" in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3—Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

16455

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16454

1. PLACE OF DEATH

a. COUNTY

ALLEGANY

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

CUMBERLAND

D O A

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

SACRED HEART

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month
DECEMBER

Day
6, 1966

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. MARRIED

X NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

JULY 6, 1907

9. AGE (In years
last birthday)

59 yrs.

IF UNDER 1 YEAR

Months Dey Hours Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

TINSMITH

10b. KIND OF BUSINESS OR INDUSTRY

KELLY-SPGFD. TIRE CO.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

WILLIAM H. LLOYD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

NO

16. SOCIAL SECURITY NO.

217-10-5000

17. INFORMANT

MRS. ELEANOR LLOYD, FROSTBURG, MD.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

420.1

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

CORONARY THROMBOSIS, LEFT

INTERVAL BETWEEN
ONSET AND DEATH
SUDDEN

CORONARY SCLEROSIS

2. MEDICAL CERTIFICATION

20e. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour e.m. Month, Day, Year
p.m. 19

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)
BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER December 6, 1966
Address (Street, city, town, or county)
Cumberland, Md.

22e. BURIAL, CREMATION,
REMOVAL (Specify)

BURIAL

22b. DATE THEREOF
12-9-1966

22c. NAME OF CEMETERY OR CREMATORIUM
FBIG. MEMORIAL PARK

22d. LOCATION (City, town, or country)
FROSTBURG, MD.

(State)

23. FUNERAL DIRECTOR

JOSEPH R. DURST, SR., FROSTBURG, MD.

ADDRESS

24e. REC'D BY REGISTRAR DEC 12 1966
24b. REGISTRAR'S SIGNATURE
Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16456

CERTIFICATE OF DEATH

16455

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN lb 2 WEEKS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) ANNA		First ANNA	Middle LLOYD	
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH JUNE 6, 1886		9. AGE (In years last birthday) 80 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS DR INDUSTRY		
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOSEPH BROWN		14. MOTHER'S MAIDEN NAME ELIZA LEE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 214-01-6658D		
17. INFIRMITY MRS. WALTER BRADLEY, FROSTBURG, MD.		Address 321 WELSH HILL,		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Cerebral Hemorrhage INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension ONSET AND DEATH (c) Arterio - Sclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Senile				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 8A. M.	20f. (City or town) FROSTBURG (County) MARYLAND (State) MD.
21. I certify that (I) (this hospital) attended the deceased from 12-1 , 19 66 , to 12-28 , 19 66 , that (I) (we) last saw the deceased alive on 12-28 19 66 , and that death occurred at 8A. M. from causes and on the date stated above.				22b. DATE SIGNED 12/29/66
22a. SIGNATURE <i>H. C. Diehl</i>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. H. C. DIEHL, M. D.	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) H. C. DIEHL, M. D.		22d. ADDRESS 39 W. MAIN ST., FROSTBURG, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC. 30 '66	23c. NAME OF CEMETERY OR CREMATORIAL FBG. MEMORIAL PARK	23d. LOCATION (City or Town) FROSTBURG, MD. (County) MARYLAND (State) MD.
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.		ADDRESS JOSEPH R. DURST, SR., FROSTBURG, MD.	25a. REC'D BY REGISTRAR CHARLES JUDGE	25b. REGISTRAR'S SIGNATURE CHARLES JUDGE

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

16457

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16456

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN lb DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BRYAN		First KIRK	Middle LLOYD
4. DATE OF DEATH DECEMBER 22, 1959		Month 18,	Year 1966
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH DEC. 22, 1959		9. AGE (In years last birthday) 6 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME WM. HENRY LLOYD		14. MOTHER'S MAIDEN NAME CAROLYN PATTERSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. NONE	17. INFORMANT MRS. CAROLYN LLOYD, FROSTBURG, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) DUE TO (c)		<i>Asphyxiation</i> Extensive body burns " " "	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Trapped in Burning Dwelling	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 300 12-18-1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Homes
20f. (City or town) Frostburg, Alleg. Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-21-66	23c. NAME OF CEMETERY OR CREMATORIAL FBG. MEMORIAL PARK
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.		23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.	
		25a. REC'D BY REGISTRAR DATE DEC 23 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

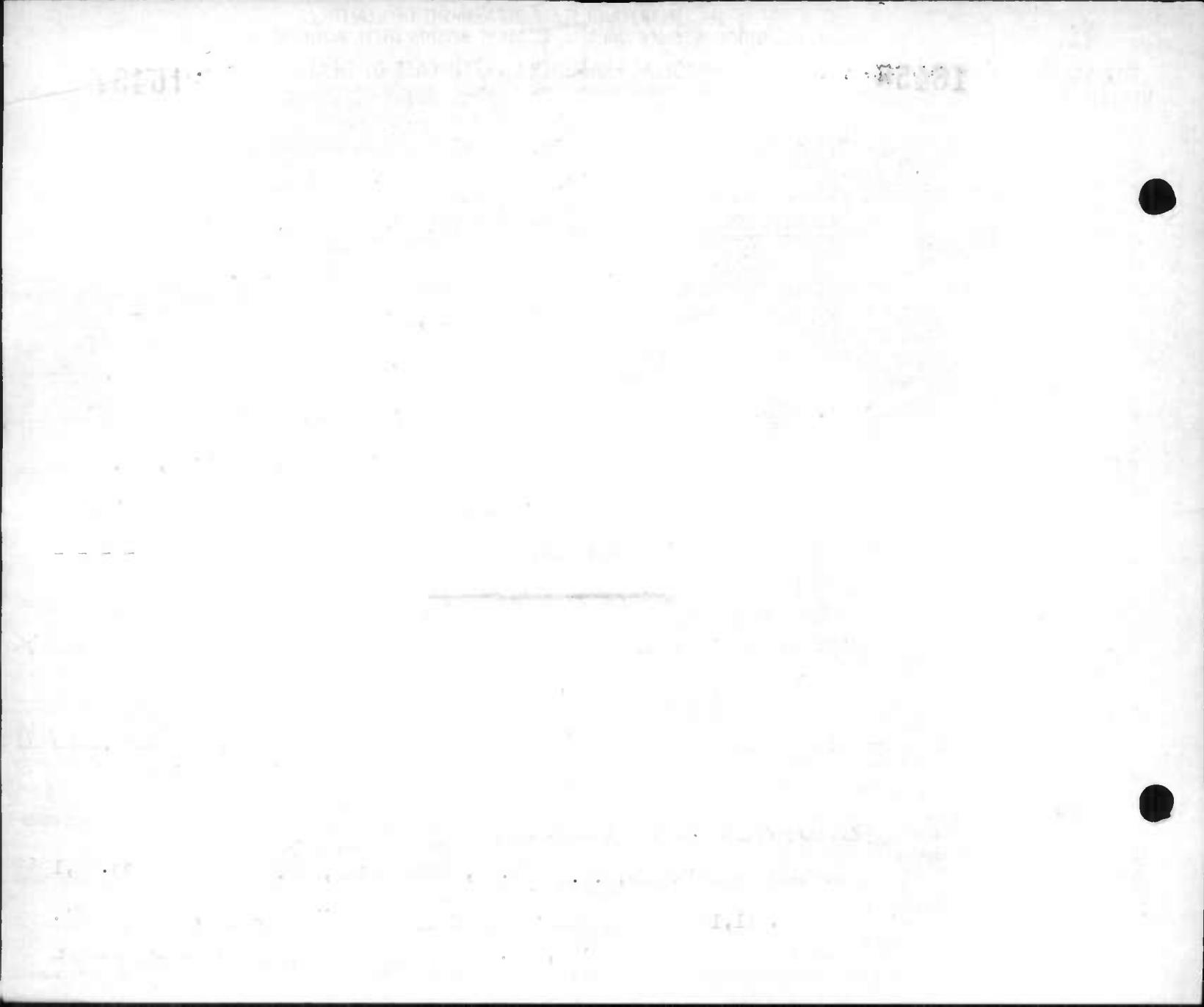
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

16458

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16457

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		b. COUNTY ALLEGANY	
c. LENGTH OF STAY IN lb 5 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 11 BROWNING ST.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First DEVONA	Middle G.	Last MANN
4. DATE OF DEATH	DEC.	Month 8	Doy 19
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH JULY 25, 1877	9. AGE (In years lost birthday) 89 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) PENNA	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME WILLIAM H. DOWNS	14. MOTHER'S MAIDEN NAME ELIZABETH CHISHOLM		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT GERTRUDE RANCK	Address CUMBERLAND, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC MYOCARDITIS			INTERVAL BETWEEN ONSET AND DEATH MONTHS 0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 422.1 (b) ARTERIOSCLEROSIS			
DUE TO (c) Fracture of right hip			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture of right hip			
20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) FELL AT HOME		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 8 10/27/1966	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Cumberland Allegany Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, MD.	22. DATE SIGNED Dec. 8, 1966		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF DEC. 11, 1966	23c. NAME OF CEMETERY OR CREMATORIUM PRESBYTERIAN CEMETERY	23d. LOCATION (City or Town) (County) (State) WARFORDSBURG, PA.
24. FUNERAL DIRECTOR BYRON KIGHT	ADDRESS CUMBERLAND, MD.	25a. REC'D BY REGISTRAR DEC 12 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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16459

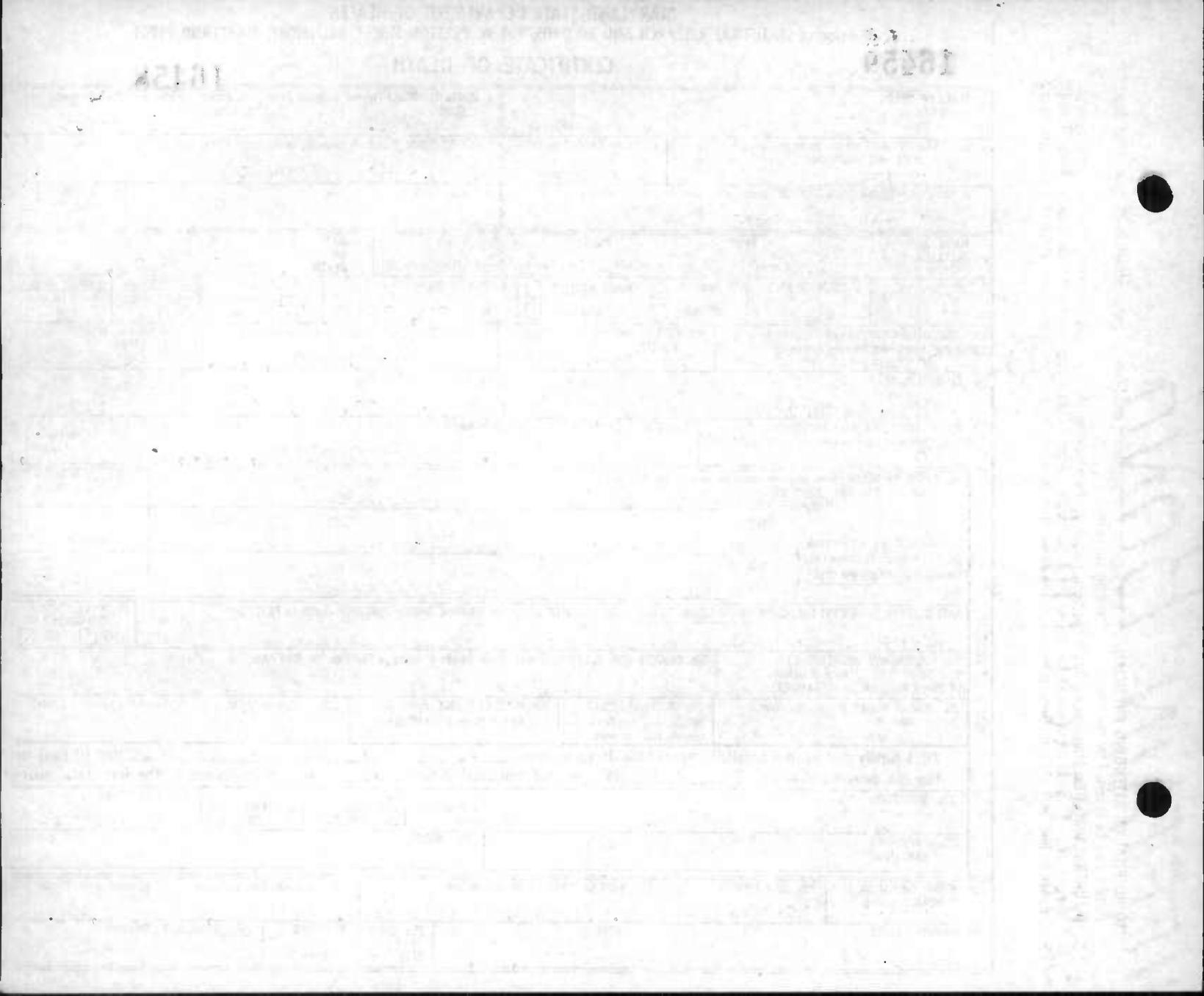
CERTIFICATE OF DEATH

16458

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician. Director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Md.		b. COUNTY Garrett		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 7 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing (Rural)		d. STREET ADDRESS 112		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Joseph Tecumseh McKenzie		First	Middle	Lost	4. DATE OF DEATH Decemb er 20, 1966	Month	Doy	Year
S. SEX M	6. COLOR OR RACE W	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH May 27, 1890	9. AGE (In years lost birthday) 76 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	Min. 0
8. OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (County & State, or foreign country) Garrett County, Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John McKenzie		14. MOTHER'S MAIDEN NAME Sarah Ellen Christner				Address Md.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Teresa Garlitz, R.D., Lonaconing,				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Acute brain syndrome						INTERVAL BETWEEN ONSET AND DEATH		
(b) DUE TO Circulatory disturbance						2 week		
(c) DUE TO Cerebral arteriosclerosis						5 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Chronic pulmonary fibrosis - encephalitis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Dec. 12, 1966 , to Dec. 20, 1966 that (I) (we) last saw the deceased alive on Dec. 20, 1966 , and that death occurred at 12:30M , from causes and on the date stated above.								
22a. SIGNATURE G. Paige Strong		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Dec. 21, 1966
22c. PHYSICIAN'S NAME (Type) 		22d. ADDRESS 						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/23/66		23c. NAME OF CEMETERY OR CREMATORIAL St. Ann's Catholic Cen.		23d. LOCATION (City or Town) (County) (State) Avilton, Garrett, Md.		
24. FUNERAL DIRECTOR Ruth E. Newman		ADDRESS Grantsville, Md.		25a. REC'D BY REGISTRAR DATE DEC 27 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16460

CERTIFICATE OF DEATH

16459

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 12 Hours				
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 45 MARION ST.				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) WALTER		First F.	Middle .			
4. DATE OF DEATH DEC. 1 1966	5. DATE OF BIRTH 10-25-1877	6. AGE (In years last birthday) 89 yrs.	7. IF UNDER 1 YEAR Months 89			
8. SEX MALE	9. IF UNDER 24 HRS. Days 24 hrs.	10. COLOR OR RACE WHITE	11. IF UNDER 24 HRS. Hours 24 hrs.			
12. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	13. FATHER'S NAME DAV+S MILLER DAVID MILLER	14. MOTHER'S MAIDEN NAME MARY ANN MILLS MARY ANN MILLS	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 212-32-8251			
16. SOCIAL SECURITY NO. 17. INFORMANT MEMORIAL HOSPITAL CUMBERLAND, MD.	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Auto myocardial fibrillation, antec- lat. DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension & A.S. Cardiowase. disease DUE TO 3 years. (c)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 10A.M. 1 Dec. 1966, to 10 P.M. 1 Dec. 1966, at 122 S. CENTRE ST., CUMBERLAND, MD.	20f. (City or town) 10A.M. 1 Dec. 1966, to 10 P.M. 1 Dec. 1966, at 122 S. CENTRE ST., CUMBERLAND, MD.	(County) 10A.M. 1 Dec. 1966, to 10 P.M. 1 Dec. 1966, at 122 S. CENTRE ST., CUMBERLAND, MD.	(State) 10A.M. 1 Dec. 1966, to 10 P.M. 1 Dec. 1966, at 122 S. CENTRE ST., CUMBERLAND, MD.
21. I certify that (I) (this hospital) attended the deceased from 10A.M. 1 Dec. 1966 , to 10 P.M. 1 Dec. 1966 , that (I) (we) last saw the deceased alive on 1 Dec. 1966 , and that death occurred 12:00 P.M. from causes and on the date stated above.	22a. SIGNATURE W. Alfred Van Ormer	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED Dec 4, 1966	22c. PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER	22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec 4, 1966	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Hillcrest Burial Park	23d. LOCATION (City or Town) (County) (State) Near Cumberland, Alleg. Md			
24. FUNERAL DIRECTOR John J. Hafer, Jr.	25a. RECEIVED BY REGISTRAR DEC 6 1966	25b. REGISTRAR'S SIGNATURE Charles Judge				

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16461

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16460

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
Allegany MARYLAND		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Cumberland DOA		d. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. STREET ADDRESS	
Sacred Heart Hospital		Bowmans Addition	
3. NAME OF DECEASED (Type or print)		First	Middle
William			
4. DATE OF DEATH		Month	Day Year
Mortzfeldt December 21 1966			
5. SEX		6. COLD OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Male White		WIDDOWED <input checked="" type="checkbox"/> DIVDRCED <input type="checkbox"/>	8. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (in years last birthday) IF UNDER 1 YEAR Months Days Hours Min.	
Retired Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
Williams Foundry Co		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY?	
Ernest Mortzfeldt		U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		14. MOTHER'S MAIDEN NAME	
No		Louise Elizabeth Reistiky	
16. SOCIAL SECURITY NO.		17. INFORMANT	
		Address	
		Route 1, Sandy Mile Rd., Hancock, Maryland	
James R. Mortzfeldt			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)		Sudden	
1420.1		---	
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		DUE TO (b)	Coronary Occlusion
		DUE TO (c)	Coronary Sclerosis
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> December 25, 1966 Address (Street, city, town, or county) Cumberland, Maryland	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		22. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/29/66	
23c. NAME OF CEMETERY OR CREMATORIAL PARK Hillcrest Burial Park		23d. LDCATIDN (City, town or county) (State) Near Cumberland, Md	
24. FUNERAL DIRECTOR John J. Hafer, Jr., 230 Balto Ave. Cumberland		25a. REC'D BY REGISTRAR DEC 29 1966	
ADDRESS		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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gentamycin

0.5 mg gentamycin

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16462

CERTIFICATE OF DEATH

16461

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 11/10/1966		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		d. STREET ADDRESS Route No. 1		
3. NAME OF DECEASED (Type or print)	First Amos	Middle C.	Last Murphy	
4. DATE OF DEATH December 16, 1966	Month	Doy	Year	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 9/18/1909	9. AGE (In years and birthday) 57 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired/Contracting	10b. KIND OF BUSINESS INDUSTRY worker & Wrkr.	11. BIRTHPLACE (County & State, or foreign country) Delaware Chaneysville, Pennsylvania	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Murphy	14. MOTHER'S MAIDEN NAME Minnie Bennette			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. 214-07-1042	17. INFORMANT P.O. Box 599, Cumberland, Md. Allegany County Infirmary records.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>350X</i> <i>3</i> <i>Paralysis, Agitans, Rest. Sore</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>③ Cryptothalamic, Belts</i> (b) DUE TO <i>④ Cerebro - Vascular disease</i> (c)				
INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 11/10/66	20f. (City or town) (County) (State) A. M. (Cumberland, Md.)
21. I certify that (I) (this hospital) attended the deceased from 12/15/66, 19, to 12/16/66, 19, that (I) (we) last saw the deceased alive on 12/15/66, 19, and that death occurred at A. M., from causes and on the date stated above.				at 5:30
22a. SIGNATURE <i>Lee B. Mathews, M.D.</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Lee B. Mathews, M. D.		22d. ADDRESS 49 Greene St., Cumberland, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 19, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park	23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS	25a. REC'D BY REGISTRAR DEC 28 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16463

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16462

1. PLACE OF DEATH o. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND		b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b <i>1 day</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 113 N. Chase Street		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) CARTS TMA		First	Middle	Lost	4. DATE OF DEATH MURPHY	Month	Day	Year
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-4-03	9. AGE (In years lost birthday) 63 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUS WIFE Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Dept. Store		11. BIRTHPLACE (County & State, or foreign country) Scottdale, Penna.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME JOHN J. SHERIDAN				14. MOTHER'S MAIDEN NAME ELIZABETH HECK				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-40-1208		17. INFORMANT PATIENT'S CHART		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction INTERVAL BETWEEN ONSET AND DEATH 10 days								
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive heart disease 5 yrs. (c) none								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Dec. 16, 1966 , to December 26, 66 that (I) (we) lost saw the deceased alive on 12-26-66 19, and that death occurred at 7:40 AM from causes and on the date stated above.								
22a. SIGNATURE <i>James P. Hallinan M.D.</i>		22b. DATE SIGNED 12-27-66						
22c. PHYSICIAN'S NAME (Type) James P. Hallinan M. D.		22d. ADDRESS 110 Bedford St., Cumberland, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/29/66		23c. NAME OF CEMETERY OR CREMATORIUM St. Patrick's Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.		
24. FUNERAL DIRECTOR H. Wayne George		ADDRESS Cumberland, Md.		25a. RECD BY REGISTRAR DATE DEC 30 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

gelot

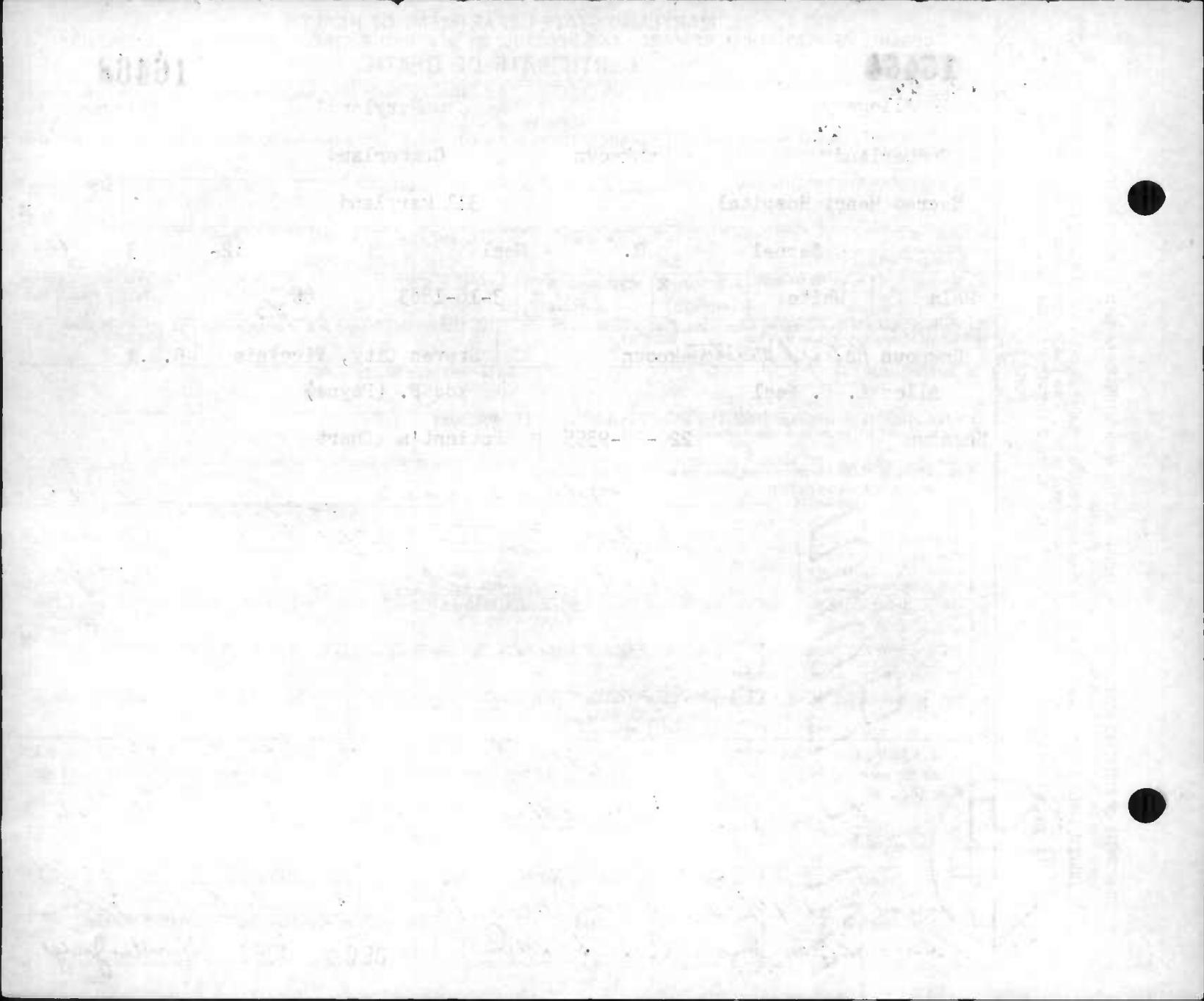
6001

and can't do so.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE				16463			
Allegany				Maryland							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b unknown				b. COUNTY Allegany			
Cumberland				Cumberland							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Sacred Heart Hospital				d. STREET ADDRESS 311 Maryland				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)				First Samuel	Middle R.	Last Neel	4. DATE OF DEATH	Month 12-	Day 3	Year 1966	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-18-1883	9. AGE (In years last birthday) 83 yrs.	10. UNDER 1 YEAR Months 0	11. UNDER 24 HRS. Days 0	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown Retired Minister Unknown				11. BIRTHPLACE (County & State, or foreign country) Steven City, Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Allen A. P. Neel				14. MOTHER'S MAIDEN NAME Ida B. (Payne)							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? UNKNOWN				16. SOCIAL SECURITY NO. 220-28-9355				17. INFORMANT Patient's Chart			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0				Malaria				INTERVAL BETWEEN ONSET AND DEATH 2 wks			
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. b) DUE TO c) DUE TO 088.0				Herpes Zoster (Lift Face) Arterosclerosis				3 wks 5 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Nov. 14, 1966, to Dec. 3, 1966, that (I) (we) last saw the deceased alive on Dec. 3, 1966, and that death occurred at M, from the causes and on the date stated above.				22b. DATE SIGNED 1966/12/03							
22a. SIGNATURE Charles L. Garrett				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
22c. PHYSICIAN'S NAME (Type) Louis Stein Inc.				22d. ADDRESS Cumb. Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/6/66		23c. NAME OF CEMETERY OR CREMATORIALy		23d. LOCATION (City, town or county) Cumberland		(State) Md.			
24. FUNERAL DIRECTOR Louis Stein Inc.		ADDRESS Cumb. Md.		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge		DATE DEC 7 1966			
25b. REGISTRAR'S SIGNATURE Charles Judge											



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16465

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16464

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Rt. # 6	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Winchester Rd.		d. STREET ADDRESS Oakwood Ave. Roberts Place	
3. NAME OF DECEASED (Type or print)	First Harry	Middle --	Last Nelson
4. DATE OF DEATH December 1, 1966	Month	Doy	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 14, 1893
9. AGE (In years last birthday) 72 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Emp'lmt Mgr.	10b. KIND OF BUSINESS OR INDUSTRY Kelly Tire Co.	11. BIRTHPLACE (State or foreign country) Akron, Ohio	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME John Nelson	14. MOTHER'S MAIDEN NAME Nellie Olsen		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No,	16. SOCIAL SECURITY NO. 214-07-0763	17. INFORMANT Mrs. Vera Nelson, Roberts Place, Cumb. Md.	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO CORONARY OCCLUSION INTERVAL BETWEEN ONSET AND DEATH SUDDEN			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO CORONARY SCLEROSIS (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Cresaptown (County) Allegany (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED December 1, 1966 Rt. # 9 Address (Street, city, town, or county) Cumberland, Md.		
EXAMINER'S NAME (Type) Benedict Skitarelic, M. D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/5/66	23c. NAME OF CEMETERY OR CREMATORIUM St. Ambrose Cemetery	23d. LOCATION (City or Town) Cresaptown (County) Allegany (State) Md.
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Maryland	ADDRESS	25a. REC'D BY REGISTRAR DATE DEC 6 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

REASER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 Film G384 1/5/67 mh

CERTIFICATE OF DEATH

16466

16465

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		CERTIFICATE OF DEATH			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 10 YRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 36 BOONE STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL									
3. NAME OF DECEASED (Type or print) MARY		First	Middle	Last	4. DATE OF DEATH DEC. 22 1966	Month	Day	Year	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH DEC. 28, 1894	9. AGE (In years last birthday) 72 71 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) ITALY -Bargotta		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME MARTIN CAPPELLETTA				14. MOTHER'S MAIDEN NAME SPANGOTTI		PATIENT'S CHART		Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		DUE TO congestive heart failure						1 day	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) stating the underlying cause		DUE TO coronary occlusion						1 day	
		(c) arteriosclerosis						2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 11-23 , 19 66 , to 12-22 , 19 66 , that (I) (we) last saw the deceased alive on 12-22-1966 , and that death occurred at _____ M, from causes and on the date stated above.									
22a. SIGNATURE Lewis Brings		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 12-25-66			
22c. PHYSICIAN'S NAME (Type) Dr. Lewis Brings, M.D.		22d. ADDRESS 57 Greene St., Cumberland, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 26, 1966		23c. NAME OF CEMETERY OR CREMATORIUM St. Mary's Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany			
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS		25a. REC'D BY REGISTRAR JAN 3 1967		25b. REGISTRAR'S SIGNATURE Charles Juge			

2001

2002

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16467

CERTIFICATE OF DEATH

16466

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND 3 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KEYSER 85-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 1050 CAROLINA AVENUE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ROBERT KENNETH NILAND		First	Middle
4. DATE OF DEATH DECEMBER 9 19 66	Month	Day	Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> X	8. DATE OF BIRTH 12-6-1966
		<input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. AGE (In years last birthday) yrs. 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT W. NILAND		14. MOTHER'S MAIDEN NAME SHARON LEE BARTLETT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.7 DUE TO CARDIAC FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO TRUNCUS ARTERIOSUS stating the underlying cause (c) DUE TO (CONGENITAL HEART)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at 4:15 P.M. from causes and on the date stated above.			
22a. SIGNATURE Robert Madell		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. ROBERT BRODELL		22d. ADDRESS 500 GREENE ST. 305X XXXXX XXXXX XXXX : CUMBERLAND, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10 Dec 1966	
23c. NAME OF CEMETERY OR CREMATORIAL Potomac Valley Park		23d. LOCATION (City or Town) (County) (State) Keyser, Mineral W.Va.	
24. FUNERAL DIRECTOR Allen M. Ratnick, Keyser, W. Va.		ADDRESS	
		25a. REC'D BY REGISTRAR DEC 16 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATEMENT
HEALTH DEPT.

16468

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16467

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS 439 CENTRAL AVE.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JAMES		First K.	Middle PALMER
4. DATE OF DEATH DEC. 25 1966		Month DEC.	Doy Year 25 19 66
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH MARCH 17, 1881		9. AGE (In years last birthday) yrs. 85	IF UNDER 1 YEAR Months 0
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GENERAL FOREMAN		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	11. BIRTHPLACE (State or foreign country) DENVER, COLORADO
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) YES		16. SOCIAL SECURITY NO. 171 03 7452	17. INFORMANT DAISY LEE PALMER
		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		Coronary Occlusion	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>(b)</i> lost. <i>(c)</i>		Coronary Sclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) CUMBERLAND, MD.
20f. (City or town) CUMBERLAND, MD.		(County) MD.	(State) MD.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>Benedict Skitarelic</i> M.D.	
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.	
22. DATE SIGNED December 25, 1966		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC. 28, 1966	23c. NAME OF CEMETERY OR CREMATORIAL SUNSET MEMORIAL PARK
23d. LOCATION (City or Town) CUMBERLAND, MD.		(County) MD.	(State) MD.
24. FUNERAL DIRECTOR <i>Byron Kight</i>		ADDRESS CUMBERLAND, MD.	25a. REC'D BY REGISTRAR DEC. 29 1966
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

60001

60001

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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16469

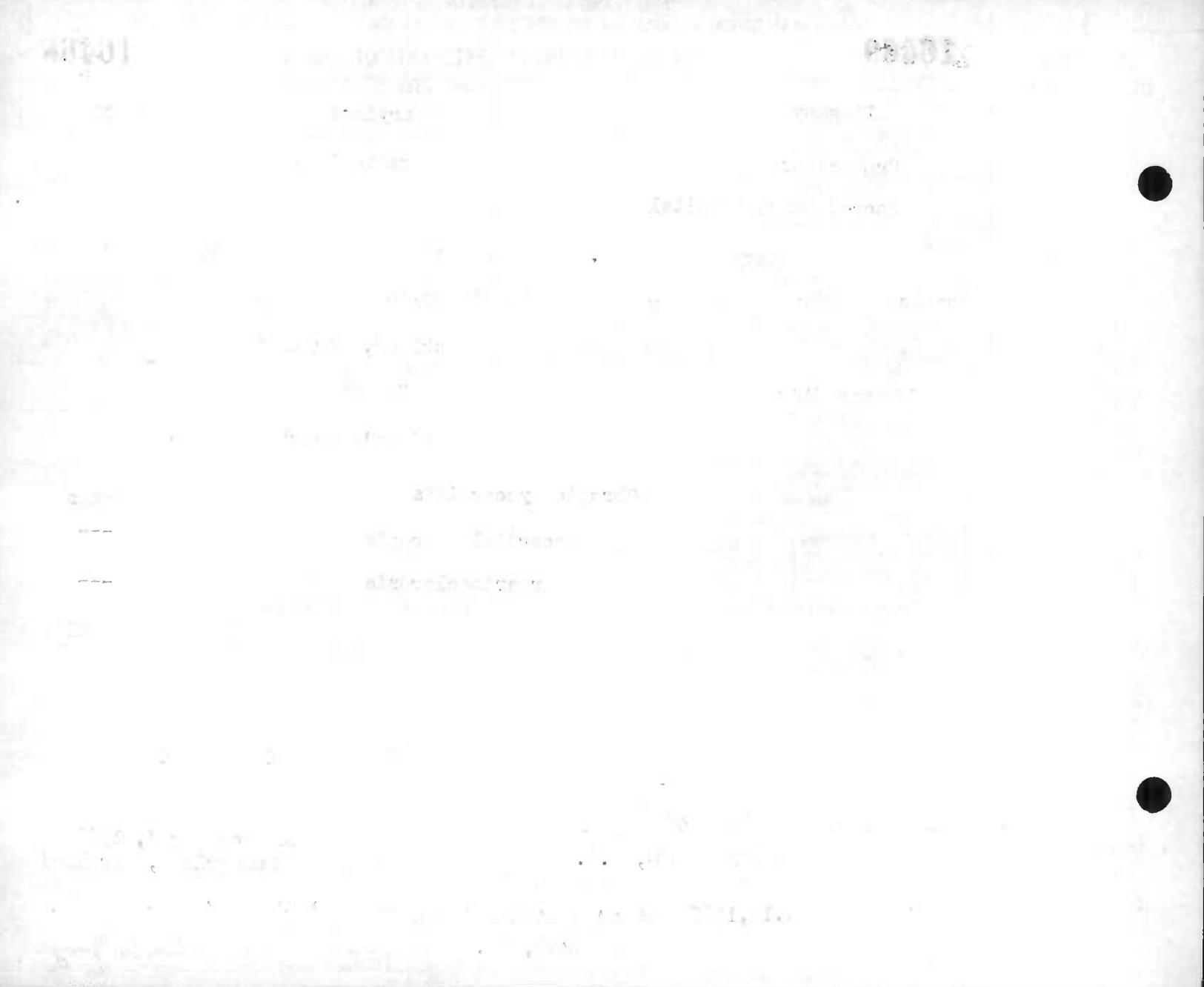
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16468

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Garrett		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grantsville		d. STREET ADDRESS 112		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Mary		First S.	Middle Payton	Lost	4. DATE OF DEATH 12	Month 7	Day 19	Year 66
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIOOWEO	NEVER MARRIED <input type="checkbox"/>	DIVORCEO <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12/30/80	9. AGE (In years lost birthday) 85 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) Oakland, Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Johnson King				14. MOTHER'S MAIDEN NAME Mary Lee				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT patient's chart		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) Chronic Myocarditis INTERVAL BETWEEN ONSET AND DEATH DUE TO 4221 Months								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Fibrosis ---								
(c) Arteriosclerosis ----								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH:		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19								
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED December 7, 1966		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC. 10, 1966		23c. NAME OF CEMETERY OR CREMATORIAL PLEASANT VALLEY CEMETERY		23d. LOCATION (City or Town) (County) (State) OAKLAND GARRETT MD.		
24. FUNERAL DIRECTOR BYRON KIGHT		ADDRESS CUMBERLAND, MD.		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge		
VR A15ME (5) 6M 1/66				DATE DEC 12 1966				

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16470

CERTIFICATE OF DEATH

16469

1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 10/14/55	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Flaville S. Percy		First Flaville	Middle S.
Last Percy	4. DATE OF DEATH Month December Day 15, Year 1966		
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>
8. DATE OF BIRTH 1/23/1881		9. AGE (In years last birthday) 85 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired! Librarian at Court House		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Douglas G. Percy		14. MOTHER'S MAIDEN NAME Anna R. Manchester	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT P.O. Box 599, Allegany County Infirmary records.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>My esophageal disease</i> 334X DUE TO <i>Severe</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Advanced Schenck's, General + cerebral</i> (c) <i>Marked cerebral degeneration</i>	
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10/14/55 , 19_____, to 12/15/66 , 19_____, that (I) (we) last saw the deceased alive on 12/15/66 , 19_____, and that death occurred at P. M. from causes and on the date stated above.			
22a. SIGNATURE <i>Lee B. Mathews</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Lee B. Mathews, M. D.		22d. DATE SIGNED 12/16/66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/19/66	23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cem.
24. FUNERAL DIRECTOR Louis Stein Inc. Cumb. MD		23d. LOCATION (City or Town) (County) (State) Cumberland, MD	
ADDRESS		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
DATE DEC 21 1966			

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- 10 -

MARYLAND STATE DEPARTMENT OF HEALTH

Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16471

CERTIFICATE OF DEATH

16471

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, page 4 may be retained by the hospital or attending physician. Director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 12 DAYS		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 1401 BEDFORD ST.							
3. NAME OF DECEASED (Type or print) WILLIAM		First E.	Middle .	Last PIPER	4. DATE OF DEATH DECEMBER 30, 1966	Month Dec	Doy 30	Year 66	
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-1-1893	9. AGE (In years lost birthday) 73 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Office Worker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Kelly S. Inc Co</i>		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME WILLIAM T. PIPER		14. MOTHER'S MAIDEN NAME MARGARET DAVIES							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. WV		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X		DUE TO <i>Cerebral Thrombosis with left hemisphere</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1 year.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO <i>Cerebral Thrombosis with left hemisphere</i>							
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 18 Dec. 1966 to 30 Dec. 1966 , that (I) (we) last saw the deceased alive on 30 Dec. 1966 , and that death occurred at 6:10 AM from causes and on the date stated above.									
22a. SIGNATURE <i>W. Alfred Van Ormer</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER		22d. ADDRESS 122 S. CENTRE ST.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/3/67		23c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cem		23d. LOCATION (City or Town) Cumberland		(County) Md (State)	
24. FUNERAL DIRECTOR <i>Louis Stein Inc. Cumb. Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 5 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16472

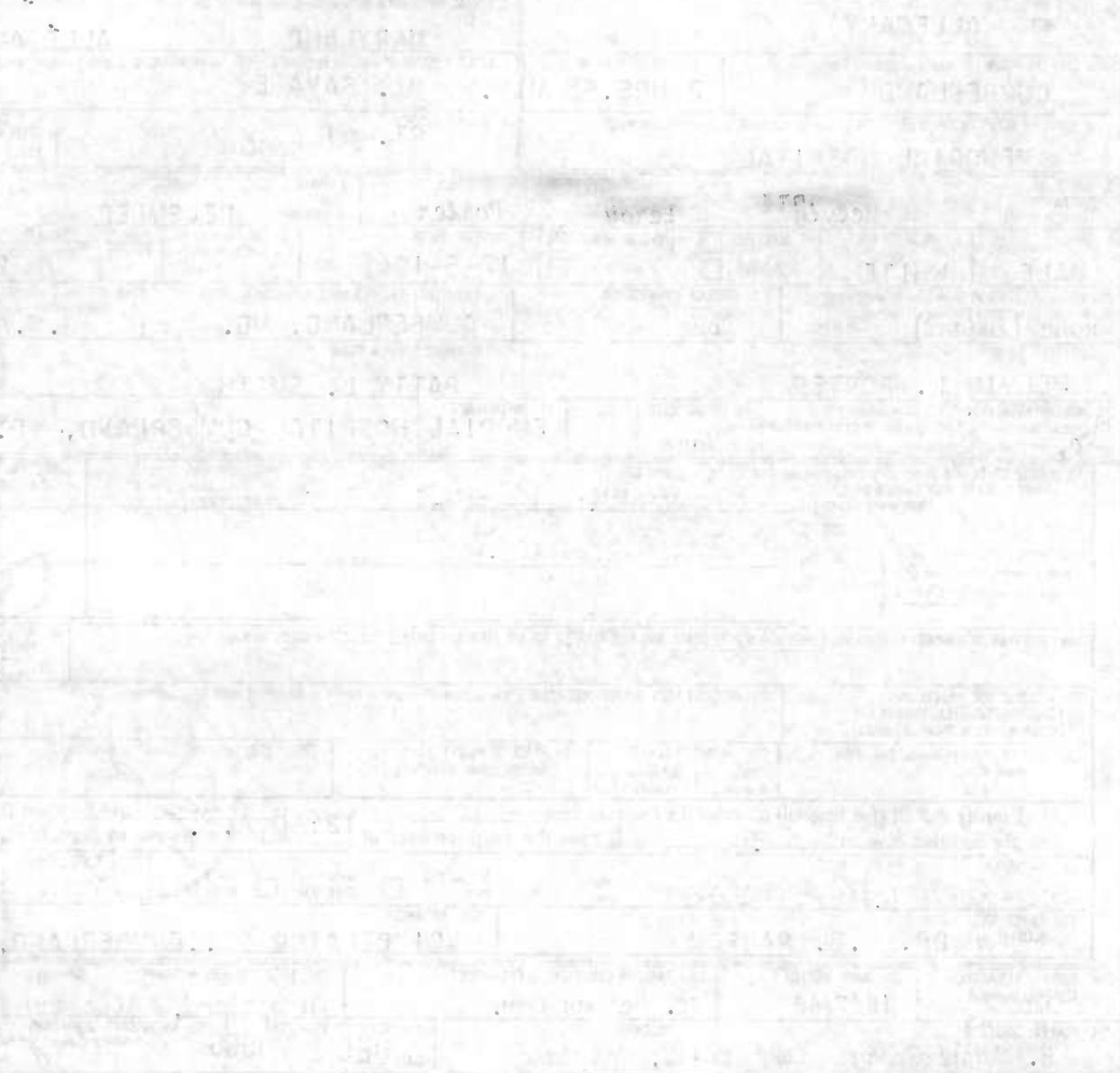
CERTIFICATE OF DEATH

16471

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 2 HRS. 58 M N. MT. SAVAGE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS RT. #1 Newtown	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Melvin	Middle L	Last Porter
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none (infant)		8. DATE OF BIRTH 12-5-1966	
10b. KIND OF BUSINESS OR INDUSTRY None		9. AGE (In years last birthday) yrs. 2 58	
13. FATHER'S NAME MELVIN L. PORTER		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No,		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO. None		14. MOTHER'S MAIDEN NAME PATTY L. SMITH	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7735 Due to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Due to last. (c) Due to			
Preivable Prematurity (Inaturity) Incompetent Cervix			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5 Dec 1966 to 6 Dec 1966, that (I) (we) last saw the deceased alive on 5 Dec 1966, and that death occurred at 12:50 P.M. from causes and on the date stated above.			
22a. SIGNATURE Leland B. Ransom		22b. DATE SIGNED 9 Dec 66	
22c. PHYSICIAN'S NAME (Type) DR. L. B. RANSOM		22d. ADDRESS 401 DECATUR ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/7/66	
23c. NAME OF CEMETERY OR CREMATORIAL Mt. Herman Cem.		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.	
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Maryland		ADDRESS	
		25a. REC'D BY REGISTRAR DEC 13 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

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FOR STATE
HEALTH DEPT.

2
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2
16473 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16472

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
<i>Allegany</i> MARYLAND		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Rural Bowmans Add Life			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
Bowmans Addition		Bowmans Addition	
e. NAME OF DECEASED (Type or print)		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
First <i>Albert</i>		Last <i>Pryor</i>	
Middle		Month <i>Dec.</i> Year <i>28, 1966</i>	
5. SEX		6. COLOR OR RACE	
Male		White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input type="checkbox"/>		9. AGE (In years last birthday) <i>78 yrs.</i>	
DIVORCED <input type="checkbox"/>		10. KIND OF BUSINESS OR INDUSTRY	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hoboror Retired</i>		11. BIRTHPLACE (State or foreign country) <i>Cumberland N. S. A.</i>	
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY?	
<i>Alexander Pryor</i>		<i>Mary Dickerhoof</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO.	
(If yes give war or dates of service) <i>WWI</i>		17. INFORMANT	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary Occlusion	
<i>420.1</i>		DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)	
Coronary Sclerosis		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>Benedict Skitarelic</i> 12-28-66	
EXAMINER'S NAME (Type) <i>Benedict Skitarelic, M.D.</i>		M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DECEMBER 28, 1966	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12/30/66</i>	
23c. NAME OF CEMETERY OR Crematory		23d. LOCATION (City, town or County) <i>Dulington Va.</i>	
24. FUNERAL DIRECTOR		ADDRESS <i>Louis Stein Inc. Cumb. 1921</i>	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
DATE JAN 5 1967		Charles Judge	



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16474

Item 25 Film G583 12/19/66 m

CERTIFICATE OF DEATH

16473

1. PLACE OF DEATH a. COUNTY ALLEGANY			MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE WEST VIRGINIA			b. COUNTY MINERAL		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN lb 2 HRS. 57 MIN.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KEYSER			d. STREET ADDRESS P.O. BOX 57		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH RAVENS CROFT			Month	Day	Year
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	X	8. DATE OF BIRTH DEC. 6, 66	9. AGE (In years lost birthday) yrs. 24 HRS.	IF UNDER 1 YEAR Months 2	IF UNDER 24 HRS. Days 57	Hours 2	Min 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME DONALD C. RAVENS CROFT			14. MOTHER'S MAIDEN NAME HAZEL C. COOK								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO lost. (c)						<i>Cremated in 20-22 weeks</i>			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred 10:29 A.M. , from causes and on the date stated above.											
22a. SIGNATURE <i>Charles S. McElroy</i>			M.D.			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			23b. DATE THEREOF 12/8/66			23c. NAME OF CEMETERY OR CREMATORIAL Memorial Hospital			23d. LOCATION (City or Town) (County) (State) Cumberland, Md.		
24. FUNERAL DIRECTOR <i>John A. McElroy</i>			ADDRESS			25a. REC'D BY REGISTRAR DATE DEC 13 1956			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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Page 2 of 3

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16475

CERTIFICATE OF DEATH

16474

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 5 HRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 523 WELCH AVENUE		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First MYRTLE	Middle ROBINETTE	Last	
4. DATE OF DEATH	Month DECEMBER	Year 5	Doy 1966	
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-11-1900	
9. AGE (In years last birthday) 66 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	11. BIRTHPLACE (County & State, or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN H. MC CARTY	14. MOTHER'S MAIDEN NAME FANNY COLEMAN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT	Address MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic heart disease</i> DUE TO <i>Arteriosclerotic heart disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>5 mo</i> 422/1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO <i>Arteriosclerotic heart disease</i> <i>3 mo</i> stating the underlying cause (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
MEDICAL CERTIFICATION	20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f. (City or town) (County) (State) <i>Cumberland Allegany MD</i>	
	21. I certify that (I) (this hospital) attended the deceased from <i>12/16/66</i> , 19 <i>66</i> , to <i>12/16/66</i> , 19 <i>66</i> , that (I) (<i>we</i>) last saw the deceased alive on <i>12/16/66</i> , 19 <i>66</i> , and that death occurred at <i>12/16/66</i> , 19 <i>66</i> , M, from causes and on the date stated above.	22b. DATE SIGNED <i>12/16/66</i>		
22c. SIGNATURE <i>R.J. Williams</i>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF DEC. 8, 1966	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS ZTON MEMORIAL PARK	23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.	
24. FUNERAL DIRECTOR BYRON KIGHT	ADDRESS CUMBERLAND, MD.		25a. REC'D BY REGISTRAR DATE DEC 8 1966	25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16476

CERTIFICATE OF DEATH

16475

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	c. LENGTH OF STAY IN LB 19 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 1120 BRADDOCK ROAD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY	First SELINA	Middle SCHANNING	4. DATE OF DEATH DECEMBER 31 1966
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-5-1906 9. AGE (In years 70 at birthday) yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) MARYLAND
13. FATHER'S NAME JOHN A BONE		14. MOTHER'S MAIDEN NAME TENNANT, MARY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 422.1 DUE TO <i>Car advanced arteriosclerotic C. & A.</i>		INTERVAL BETWEEN ONSET AND DEATH Since 1958.	
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <i>Diabetes Mellitus - Severe</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 12-12-66 to 12-31-1966 that (I) (we) last saw the deceased alive on 12-31-1966 and that death occurred at M. from causes and on the date stated above.			
22a. SIGNATURE <i>John J. Williams</i>		22b. DATE SIGNED 1-1-67	
22c. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 4, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park
23d. LOCATION (City or Town) (County) (State) Near Cumberland Alleg Md		23e. REG'D BY REGISTRAR JAN 4 1967	
24. FUNERAL DIRECTOR <i>John J. Hafer Jr.</i> ADDRESS John J. Hafer, Jr. 230 Baltz Ave. Cumberland Md		25b. REGISTRAR'S SIGNATURE <i>Jessie Judge</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

16476

16477

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 531 Greene St.		d. STREET ADDRESS 531 Greene St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Robert		First	Middle
		Sell	Last
4. DATE OF DEATH December 20, 1966		Month	Day
		Year	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
		8. DATE OF BIRTH Aug. 15, 1911	
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Buyer		10b. KIND OF BUSINESS OR INDUSTRY Dept. Store	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George J. Sell		14. MOTHER'S MAIDEN NAME Nellie Sullivan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes, W. W. # 2		16. SOCIAL SECURITY NO. 214-05-4876	
17. INFORMANT Mrs. Beatrice E. Sell 531 Greene St. Cumb. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction		1 day	
DUE TO 420.1			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Hypertensive heart disease		5 yrs.	
DUE TO (c) Coronary insufficiency		5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 13, 1961 , to Dec. 20, 1966 , that I last saw the deceased alive on Dec. 20, 1966 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 140 Bedford St. DATE SIGNED 12/22/66	
ACTUAL SIGNATURE James P. Hallinan M.D.		22. LOCATION (City, town, or county) Cumberland, Allegany Maryland	
PHYSICIAN'S NAME (Type) James P. Hallinan, M.D.		23. BURIAL, CREMATION, REMOVAL (Specify) Burial 12/23/66	
22b. DATE THEREOF 12/23/66		22c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George Cumberland, Maryland		22d. LOCATION (City, town, or county) Cumberland, Allegany Maryland	
ADDRESS		24a. REC'D BY REGISTRAR DATE DEC 27 1966	
		24b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

БІЗОНІТІВ - НОВИЙ ТЕХНОЛОГІЧНИЙ СТАНДАРТ

НАБІГУЮЩІХ ПІДСТАНДАРТІВ

1
FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

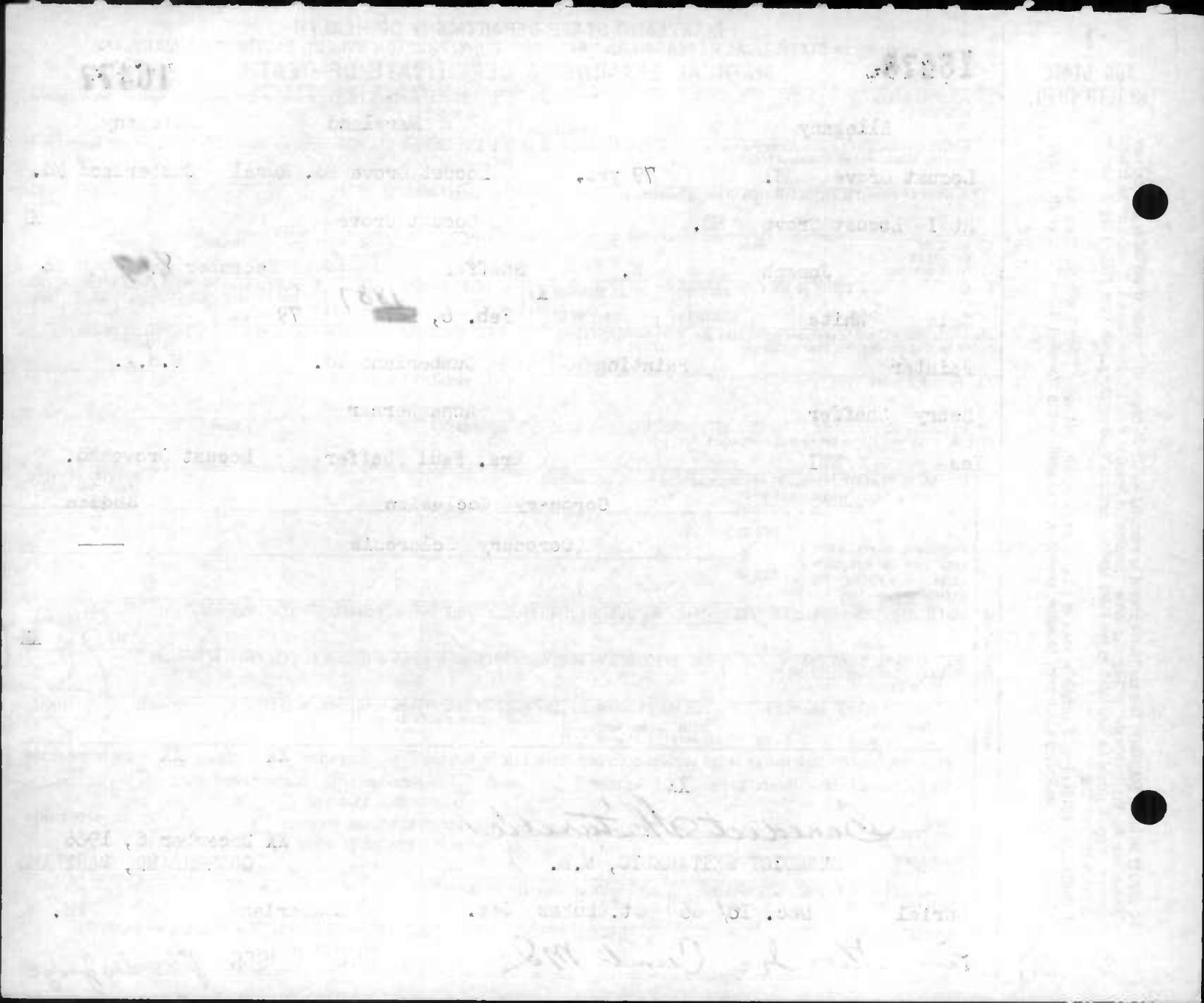
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 4 Film G384 3/12/67 4th

16478 **16477**

1. PLACE OF DEATH a. COUNTY Allegany		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Locust Grove Md.		c. LENGTH OF STAY IN 1b 49 yrs.		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt#1 Locust Grove Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Locust Grove Md. Rural		d. STREET ADDRESS Locust Grove			
3. NAME OF DECEASED (Type or print)	First Joseph	Middle W.	Last Shaffer	4. DATE OF DEATH December 8, 1966	Month Dec.	Day 8	Year 1966		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1887	9. AGE (In years last birthday) 79 yrs.	10. IF UNDER 1 YEAR Months 0	Days 0	11. IF UNDER 24 HRS. Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Painting		11. BIRTHPLACE (State or foreign country) Cumberland Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Henry Shaffer		14. MOTHER'S MAIDEN NAME Anna Werner		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 17. INFORMANT		Address Mrs. Paul Shaffer Locust Grove Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 420.1		DUE TO Coronary Occlusion		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Sudden			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis		DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Cumberland	(County) MARYLAND	(State) MARYLAND	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED December 8, 1966	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		Address (Street, city, town, or county) CUMBERLAND, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 10/66		23c. NAME OF CEMETERY OR CREMATORIUM St. Lukes Cem.		23d. LOCATION (City, town or county) Cumberland		(State) Md.	
24. FUNERAL DIRECTOR <i>Lewis Stein Inc. Cumb. Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR DEC 12 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE	
VR AISM (5) 5M 1/65									



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16479

CERTIFICATE OF DEATH

16478

Page 4 may be retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MINERAL Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE WEST. VA.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELEY Cumberland		c. LENGTH OF STAY IN lb 1 DAY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ROBERT	Middle I.	4. DATE OF DEATH SHAW DEC. 21 1966
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-20-1908
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) B Rakeman		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (County & State, or foreign country) MARYLAND * CUMBERLAND
13. FATHER'S NAME AMOS SHAW		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY ND.	17. INFORMANT MEMORIAL HOSPITAL
		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Haemorrhage with left hemiplegia 422.1 DUE TO Latest congestive heart failure 6 months Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A. S. Cardiovascular disease 8 years (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Obesity			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Apr. 1958 to 21 Dec. 1966 , that (I) (we) last saw the deceased alive on 21 Dec. 1966 and that death occurred at 6:55 P.M. from causes and on the date stated above.			
22a. SIGNATURE W. Alfred Van Ormer		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER		22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 24, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park
23d. LOCATION (City or Town) (County) (State) Cumberland, Md. - Allegany		23e. REC'D BY REGISTRAR 1413	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS	25b. REGISTRAR'S SIGNATURE 1967 Charles J. Young

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QMA 1230H

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH			16479		
1. PLACE OF DEATH a. COUNTY Allegany				MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland				b. COUNTY Allegany					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cresaptown				d. STREET ADDRESS Meadowview Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital																	
3. NAME OF DECEASED (Type or print)		First John		Middle Harrison		Last Skelley		4. DATE OF DEATH		Month 12	Day 13	Year 1966					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/16/82		9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Former Crane Operator				10b. KIND OF BUSINESS OR INDUSTRY Ship Yards				11. BIRTHPLACE (County & State, or foreign country) Penna, Bedford				12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME John Skelley				14. MOTHER'S MAIDEN NAME Rachael Thomas													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 213-22-4058				17. INFORMANT patient's chart				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Congestive heart failure												INTERVAL BETWEEN ONSET AND DEATH Months 1 year					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1																	
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO (b) congestive (c) failure													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) anemia, sclerotic												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED at work <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) 57 Greene St. Cumberland, Md.		(County) Cresaptown, Allegany Md.			
21. I certify that (I) (this hospital) attended the deceased from 11-25 , 19 66 , to 11-13 , 19 66 , that (I) (we) last saw the deceased alive on 11-13- 1966 , and that death occurred at 8:10 M, from the causes and on the date stated above.												22b. DATE SIGNED 12-14-66					
22a. SIGNATURE L. Brings												M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) Lewis Brings, M.D.												22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12/16/66				23c. NAME OF CEMETERY OR CREMATORIAL St. Ambrose Cemetery				23d. LOCATION (City, town or county) (State) Cresaptown, Allegany Md.					
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Maryland												25a. REC'D BY REGISTRAR DATE DEC 19 1966				25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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3 1 **M** 10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 8,9 Film G384 1/9/67 mh

CERTIFICATE OF DEATH

16481

16480

1. PLACE OF DEATH o. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 62 DAYS						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 312 CECELIA ST.						
3. NAME OF DECEASED (Type or print) SUSAN E SPICER		First	Middle	Lost	4. DATE OF DEATH DEC, 20	Month	Day	Year
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH SEPT. 6, 1892	8. AGE (In years last birthday) 74	9. IF UNDER 1 YEAR Months 113	10. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) LITTLE ORLEANS, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME EDWARD H. SHIELDS		14. MOTHER'S MAIDEN NAME MARY A. FAHEY						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-52-9919T		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Arteriobdominal carcinomatosis Probable primary liver				INTERVAL BETWEEN ONSET AND DEATH 6 months		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO								
(c) DUE TO								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Heart Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 10-22, 1966 , to 12-20, 1966 that (I) (we) last saw the deceased alive on 12/19 1966 , and that death occurred at 5 A.M. from causes and on the date stated above.								
22a. SIGNATURE Andrew Stasko		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/20/66		
22c. PHYSICIAN'S NAME (Type) Dr. Andrew Stasko		22d. ADDRESS 401 Decatur St, Cumberland Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 23, 1966		23c. NAME OF CEMETERY OR CREMATORIAL St. Mary's Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany		
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS James F. Scarpelli, Cumberland, Md.		25a. REC'D. BY REGISTRAR DEC 28 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		
VR A15 (4) 20 M 1/66								

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16482

CERTIFICATE OF DEATH

16481

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1. PLACE OF DEATH o. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle STEVENSON	4. DATE OF DEATH 12/16/1966
5. SEX Male	6. COLOR OR RACE White	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/7/1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Midland	9. AGE (In years lost birthday) 67 yrs.
13. FATHER'S NAME Jacob Stevenson		14. MOTHER'S MAIDEN NAME Elizabeth Mullen	12. CITIZEN OF WHAT COUNTRY? USA
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes World War # 1		16. SOCIAL SECURITY NO.	17. INFORMANT Sarah Weinbrenner
			Address Cumberland, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 443 X Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) DUE TO DUE TO (c)		Rt. heart failure (Neice) H CVD & arteriosclerosis	INTERVAL BETWEEN ONSET AND DEATH 4 days - 2 yrs -
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Dec 5, 1966 to Dec 16, 1966
20f. (City or town) M		(County) Charles Judge	(State) MD.
21. I certify that (I) (this hospital) attended the deceased from Dec 5, 1966 to Dec 16, 1966 that (I) (we) last saw the deceased alive on Dec 16, 1966 , and that death occurred on Dec 16, 1966 M, from causes and on the date stated above.			
22a. SIGNATURE John B. Davis		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 12/16/66
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/18/1966	23c. NAME OF CEMETERY OR CREMATORIALy Memorial Park
24. FUNERAL DIRECTOR GEORGE EICHORN		ADDRESS Lonaconing, MD.	25a. REC'D BY REGISTRAR DATE DEC 19 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16483

CERTIFICATE OF DEATH

16482

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 65 WASHINGTON STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. STREET ADDRESS 65 WASHINGTON ST.			
3. NAME OF DECEASED (Type or print)	First BERTHA	Middle STOOPS	Last DECEMBER 16, 1966
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 26, 1871
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALBERT ECKMAN		14. MOTHER'S MAIDEN NAME JEAN FURREE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT		Address ISABELLE STOOPS, FROSTBURG, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute brain syndrome</i> 334X DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral arteriosclerosis</i> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 24 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Aug 15</i> , 1966, to <i>Dec 16</i> , 1966, that (I) (we) last saw the deceased alive on <i>Dec 16</i> , 1966, and that death occurred at <i>1617 E. Main St.</i> , from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE <i>G. Paige Strong</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) A. P. STRONG, M. D.		22d. ADDRESS 1617 E. MAIN ST., FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC. 18, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL FBG. MEMORIAL PARK		23d. LOCATION (City, town or county) (State) FROSTBURG, MD.	
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.		ADDRESS	
		25a. REC'D BY REGISTRAR DEC 21 1966	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

63181

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MARYLAND STATE DEPARTMENT OF HEALTH

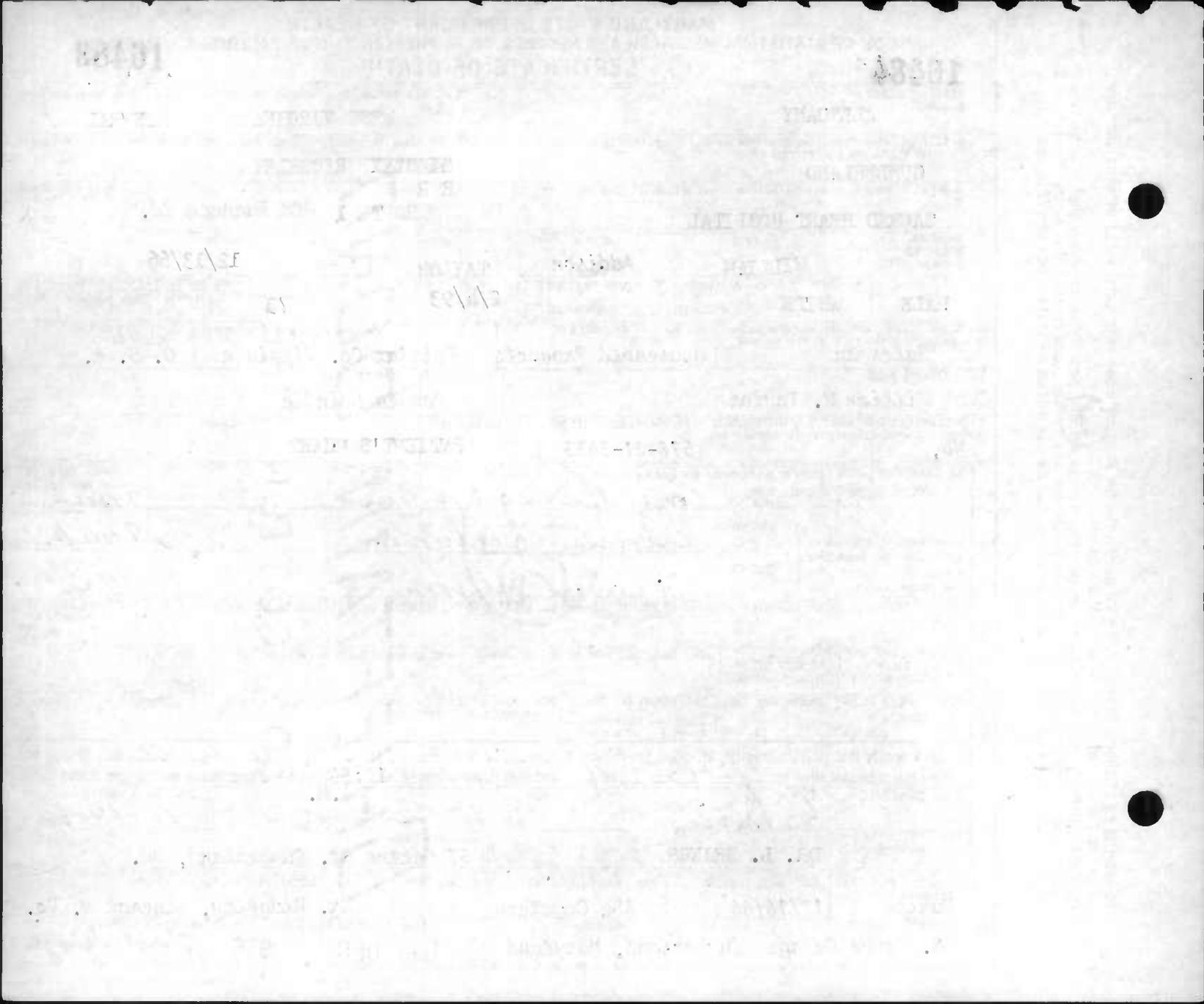
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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16484		16483	
1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. STATE WEST VIRGINIA b. COUNTY MINERAL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS ROUTE 1 Old Furnace Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle Addison	Last TAYLOR
4. DATE OF DEATH	Month 12/13/66	Day 19	Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 2/4/93
	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (in years last birthday) 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Household Products	
11. BIRTHPLACE (County & State, or foreign country) Fairfax Co. Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William W. Taylor		14. MOTHER'S MAIDEN NAME Ponola Spindle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-01-3933	
17. INFORMANT PATIENT'S CHART		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO congestive heart failure Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO coronary aclerosis (c) DUE TO coronary sclerosis		2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		2 weeks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> Not White at work <input type="checkbox"/> p.m. 19		20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 12-2-1966, to 12-13-1966, that (I) (we) last saw the deceased alive on 12-13-1966, and that death occurred at 12:5 M, from the causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE L. Brings		A.M. 22b. DATE SIGNED 12-14-66	
22c. PHYSICIAN'S NAME (Type) DR. L. BRINGS		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 57 Greene St. Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/16/66	
23c. NAME OF CEMETERY OR CREMATORIAL Abe Cemetery		23d. LOCATION (City, town or county) (State) Nr. Ridgeley, Mineral W. Va.	
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Maryland		ADDRESS	
25a. REC'D BY REGISTRAR DATE DEC 19 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16485

CERTIFICATE OF DEATH

16484

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 7 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			d. STREET ADDRESS 405 PULASKI ST.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First ETHELYN	Middle M	Last THOMPSON	4. DATE OF DEATH Month DEC. Day 6 Year 1966	Day Year
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 16, 1888	9. AGE (In years at birthday) 80 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) DELAWARE	
13. FATHER'S NAME FREDERICK DODD			14. MOTHER'S MAIDEN NAME MINNIE GOULDEN		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 217-10-6541		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Emphysema, gen., postular, chest. and</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 years.</i> <i>170X</i> DUE TO <i>3 vertebra column</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO <i>Carcinoma left breast</i> <i>12 years</i> stating the underlying cause (c) <i>last.</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Obesity and A.S. Cardiovascular disease.</i>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan. 16, 1965</i> , to <i>6 Dec. 1966</i> , that (I) (we) last saw the deceased alive on <i>5 Dec. 1966</i> , and that death occurred <i>10:15 A.M.</i> from causes and on the date stated above.					
22a. SIGNATURE <i>W. Alfred Van Ormer, Jr.</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>6 Dec. 66</i>
22c. PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER		22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 9, 1966	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Hillcrest Burial Park	23d. LOCATION (City or Town) (County) (State) Near 610 Cumberland, AllegCo	
24. FUNERAL DIRECTOR <i>John J. Hafer, Jr.</i>		230 Baltimore Ave.	Cumberland	25a. REC'D BY REGISTRAR DEC 9 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
VR A15 (4) 20 M 1/68		Md.			

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

16486

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16485

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to a burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rawlings <i>01-1</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital Cumberland, Md		d. STREET ADDRESS R.D. # 3	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Minnie	Middle B.	Last Thrasher
4. DATE OF DEATH	Month Dec.	Month 30	Day Year 1966
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Sept. 17, 1876	9. AGE (In years lost birthday) 90 yrs.	10. IF UNDER 1 YEAR Months 3 Days 13	11. IF UNDER 24 HRS. Hours 13 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired House Wife		11. BIRTHPLACE (State or foreign country) Petersburg, W. Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT LeRoy House, McCoole, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
Coronary Occlusion			
Coronary Thrombosis		"	
Coronary Sclerosis		-----	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22. DATE SIGNED December 30, 1966	
23b. DATE THEREOF 1-2-67		23c. NAME OF CEMETERY OR CREMATORIUM Dawson Cemetery	
23d. LOCATION (City or Town) (County) (State) Dawson, Md. Allegany		25a. REC'D BY REGISTRAR DATE JAN 3 1967	
24. FUNERAL DIRECTOR <i>Thomas Smith Jr.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
ADDRESS Keyser, W. Va.			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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16487

CERTIFICATE OF DEATH

16486

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG	c. LENGTH OF STAY IN 1b ½ HR.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ECKHART	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle H.	Last TWIGG
4. DATE OF DEATH	Month DECEMBER	Day 10,	Year 1966
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH JANUARY 1, 1907
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR BOBBIN STORES		10b. KIND OF BUSINESS OR INDUSTRY CELANESE CORP.	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RILEY L. TWIGG		14. MOTHER'S MAIDEN NAME NAOMI ANDREWS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 214-07-5984	
17. INFORMANT MRS. MARY M. TWIGG, ECKHART, MD.		Address	
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anorexia + cachexia DUE TO 1533 INTERVAL BETWEEN ONSET AND DEATH one month			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Carcinoma of sigmoid with local, peritoneal and liver metastases DUE TO 4-6 months			
C. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/30, 1966 , to 12/10, 1966 , that (I) (we) last saw the deceased alive on 12/4, 1966 , and that death occurred at 8 AM , from causes and on the date stated above.			
22a. SIGNATURE <i>Thomas F. Lewis</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 12/12/66
22c. PHYSICIAN'S NAME (Type) THOMAS F. LEWIS, M. D.		22d. ADDRESS 500 GREENE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC. 13 '66	
23c. NAME OF CEMETERY OR CREMATORIUM ECKHART CEMETERY		23d. LOCATION (City or Town) (County) (State) ECKHART, MD.	
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.		ADDRESS	25a. REC'D BY REGISTRAR DATE DEC 16 1966
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16487

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Allegany</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>West Virginia</i>		b. COUNTY <i>Mineral</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumberland</i>		c. LENGTH OF STAY IN lb <i>DOA</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rt. # 2 Keyser, W. Va.</i>		d. STREET ADDRESS <i>Short Gap</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Memorial Hospital</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Lloyd Logan Umstot</i>		First	Middle	Last	4. DATE OF DEATH <i>Dec. 26, 1966</i>	Month	Day Year
S. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/15/09</i>	9. AGE (In years last birthday) <i>57 yrs.</i>	IF UNDER 1 YEAR Months <i>57</i>	IF UNDER 24 HRS. Days Hours Min. <i>0 0 0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mechanic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Ballistics Lab.</i>		11. BIRTHPLACE (State or foreign country) <i>Short Gap, W. Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Ulisses G. Umstot</i>		14. MOTHER'S MAIDEN NAME <i>Delara Skelly</i>		Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> (If yes give war or dates of service) <i>W.W. # II</i>		16. SOCIAL SECURITY NO. <i>232-26-1984</i>		17. INFORMANT <i>Mrs. Ethel Umstot</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>976X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) stating the underlying cause (c) DUE TO <i>Gunshot of Head</i> (Self Inflicted)	
						INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Benedict Skitarelic, M.D.</i>		EXAMINER'S NAME (Type) <i>BENEDICT SKITARELIC, M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <i>December 26, 1966</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12/29/66</i>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Fort Ashby Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Fort Ashby, Mineral, W. Va.</i>	
24. FUNERAL DIRECTOR <i>H. Wayne George</i>				25a. REC'D BY REGISTRAR <i>DEC 30 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16489

CERTIFICATE OF DEATH

16488

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 50 years	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 733 Hilltop Drive		d. STREET ADDRESS 733 Hilltop Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First C.	Middle Glenn	Last Watson
4. DATE OF DEATH Dec. 3 1966	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1887
9. AGE (In years last birthday) 79 yrs.	10. KIND OF BUSINESS OR INDUSTRY Insurance & Real Estate-Snow Shoe, Pa.	11. BIRTHPLACE (County & State, or foreign country) Estate-Snow Shoe, Pa.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Mitchell Watson	14. MOTHER'S MAIDEN NAME Susan ?		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. 214-32-3025	17. INFORMANT Mr. David M. Watson, Cumberland, Md.-Son	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma ampulla of Vater		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
155.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	20d. INJURY OCCURRED Whila at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from 1964 , 19..., to 1966 , 19..., that (I) (we) last saw the deceased alive on Nov. 1966 , and that death occurred at... M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Carlton Brinsfield, M.D.</i>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22b. DATE SIGNED Dec. 6, 1966	
22c. PHYSICIAN'S NAME (Type) Dr. Carlton Brinsfield, M.D.	22d. ADDRESS 401 Decatur St., Cumberland, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 6, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park	23d. LOCATION (City, town or county) (State) Cumberland, Md. Allegany
24 FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.	ADDRESS	25a. REC'D BY REGISTRAR DATE DEC 9 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16489

FOR STATE
HEALTH DEPT.

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal from any event within 72 hours after death.

16490		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
1. PLACE OF DEATH o. COUNTY Allegany		o. STATE West Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		b. COUNTY Morgan	
c. LENGTH OF STAY IN 1b 73 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Paw Paw	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles B. Weaver		First	Middle
4. DATE OF DEATH December 3 1966		Month	Day Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 12-8-1885		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Dots Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George Weaver		14. MOTHER'S MAIDEN NAME Dora Martin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address Memorial Hospital-Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO last. (c)		INTERVAL BETWEEN ONSET AND DEATH Months	
Chronic Myocarditis			
Arteriosclerotic Cardiovascular disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/5/1966	23c. NAME OF CEMETERY OR CREMATORIAL Camp Hill
24. FUNERAL DIRECTOR <i>Johnson</i>		ADDRESS Johnson Funeral Home Berkeley Spgs. W.	
25a. REC'D BY REGISTRAR Va.		25b. REGISTRAR'S SIGNATURE 1966 <i>Charles Judge</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

16491

16490

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN 1b

Hours

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Memorial Hospital

3. NAME OF
DECEASED
(Type or print)First
Mamie

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

Wenrich

December

4

19 66

5. SEX

Female

6. COLOR OR RACE

White

WIDOWED

XX

NEVER MARRIED

DIVORCED

8. DATE OF BIRTH

March 21, 1878

9. AGE (in years)
last birthday

88 yrs.

Months

Days

Hours

Min.

1Da. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

1bb. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Martin Martin

14. MOTHER'S MAIDEN NAME

Margaret Shilling

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Mrs. Warren Smith, 44 Marion St., Cumberland, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e)

CHRONIC MYOCARDITIS

INTERVAL BETWEEN
ONSET AND DEATH
MONTHS422.1
Conditions, If any, which gave rise to immediate cause (e), stating the underlying cause last.

(b)

DUE TO

ARTERIOSCLEROTIC CARDIOVASCULAR

DISEASE

(c)

DUE TO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 1920d. INJURY OCCURRED
While at work Not While at work
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL
SIGNATURES

Benedict Skitarelic

M.D. ASSISTANT MEDICAL EXAMINER

22. DATE SIGNED

EXAMINER'S
NAME (Type)

BENEDICT SKITARELIC, M.D.

DEPUTY MEDICAL EXAMINER December 4, 1966

Address (Street, city, town, or county) Cumberland, Md.

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE THEREOF

Dec. 7, 1966

23c. NAME OF CEMETERY OR CREMATORIUM

German Beneficial Cemetery

23d. LOCATION (City, town or county)

Cumberland

(State)

Maryland

24. FUNERAL DIRECTOR

John J. Hafer

ADDRESS

230 Balt

Ave. Cumberland

Md.

25a. REC'D BY REGISTRAR

DEC 7 1966

25b. REGISTRAR'S SIGNATURE

Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16482

CERTIFICATE OF DEATH

16491

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE b. COUNTY Maryland Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 12 days		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 01.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		d. STREET ADDRESS 803 Maryland Ave.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Asa M. Whetsell		4. DATE OF DEATH 12/17/1966	Month Day Year
5. SEX Male White 6. COLOR OR RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/5/93	9. AGE (In years last birthday) 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired School Teacher		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Kingwood, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jonathan Whetsell		14. MOTHER'S MAIDEN NAME Ellen Bucklew	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 235-20-8220	17. INFORMANT Pt's Chart
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490X Phenyluria, RLL organisms ? DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. PART II Diabetes mellitus DUE TO PART III Hepatocarcinoma (c) Atherosclerotic heart Disease & previous hypertension Lupus erythematosus;		INTERVAL BETWEEN ONSET AND DEATH 17 days Part II	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 12/17/66 Carroll
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 12/16 1966, and that death occurred at 12 AM, from the causes and on the date stated above.		22b. DATE SIGNED 12/17/66	
22a. SIGNATURE Dr. Weissman		ATTENDING M.D. PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 12/17/66
22c. PHYSICIAN'S NAME (Type) S. G. WEISSMAN MD		22d. ADDRESS Cumberland Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/19/66	23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park
24. FUNERAL DIRECTOR		23d. LOCATION (City, town or county) (State) Cumberland Allegany Maryland	
ADDRESS H. Lee Silcox Cumberland Maryland 21502		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE Charles Judge

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Document 10881
Volume 10881

Section 10881
Volume 10881

File # 10881-000

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16493

CERTIFICATE OF DEATH

16492

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN lb 11/8/66	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		d. STREET ADDRESS 167 N. Centre Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle	4. DATE OF DEATH December 27, Month 1966 Day Year		
S. SEX Male 6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/5/1877	9. AGE (In years last birthday) yrs. 89
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired: Merchant		11. BIRTHPLACE (County & State, or foreign country) Cumberland, Maryland	
12. CITIZEN OF WHAT COUNTRY U. S. A.			
13. FATHER'S NAME Herman White		14. MOTHER'S MAIDEN NAME Betty Ley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT P.O. Box 599, Address Cumberland, Md. Allegany County Infirmary records.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① Myocarditis, chronic, degenerative, Severe 422.2 Due to (b) ② Arteriosclerosis, general & cerebral stating the underlying cause (c) ③ Neuritis, degeneration INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 11/8/1966, 1966, to 12/27/1966 that (I) (we) last saw the deceased alive on 12/27/1966, and that death occurred at A. M. from causes and on the date stated above. at 10:05 A. M.			
22a. SIGNATURE Lee B. Mathews, M. D.		22b. DATE SIGNED 10/28/1966	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 49 Greene St. Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/30/66	
23c. NAME OF CEMETERY OR CREMATORIAL Facility		23d. ADDRESS	
24. FUNERAL DIRECTOR Louis Stein Inc. Cumb. Md.		25a. REC'D BY REGISTRAR C. J. Charles Judge	
25b. REGISTRAR'S SIGNATURE			
DATE JAN 3 1967			

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

16494

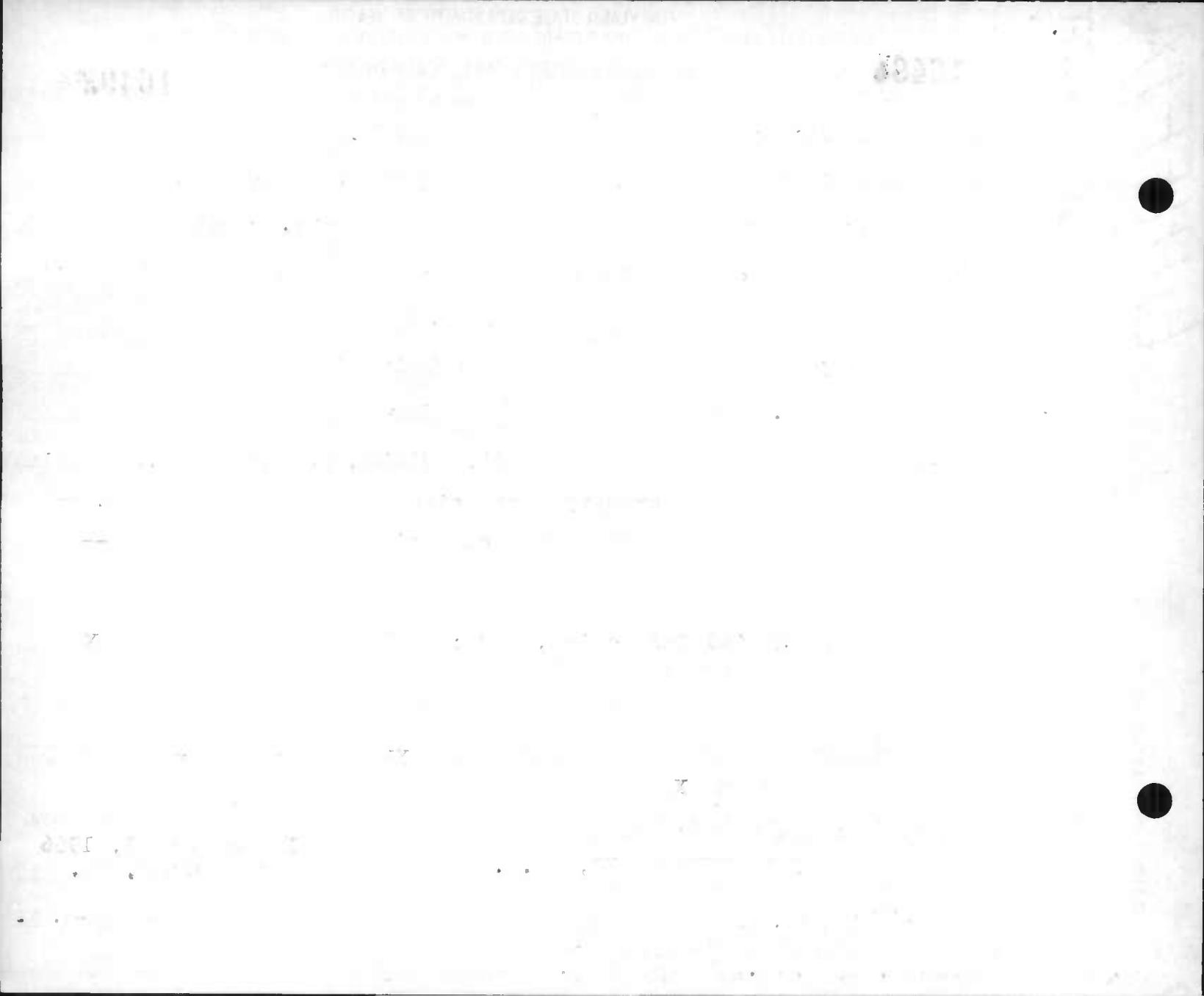
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16493

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland D.O.A.		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS 307 Harrison Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Bessie	Middle Elizabeth	4. DATE OF DEATH December 1 1966
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 3, 1898
10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME John W. Boone		14. MOTHER'S MAIDEN NAME Lucy Conard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Allen Wilkins, 303 Harrison St., Cumberland	
17. INFORMANT		Address Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 420.1 (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden --	
Coronary Sclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Myocardial Infarction, Left; OLD			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> December 1, 1966	
		Address (Street, city, town, or county) Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 5, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Asbury Methodist Cemetery
23d. LOCATION (City or Town) (County) (State) Near Moorefield-Hardy-W. Va.		23e. DATE REC'D BY REGISTRAR DEC 5 1966	
24. FUNERAL DIRECTOR John J. Hafer, Jr.		25b. REGISTRAR'S SIGNATURE Charles Judge	ADDRESS 230 Balti' Ave. Cumberland
		DATE DEC 5 1966	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16495.

CERTIFICATE OF DEATH

16494

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in event of removal, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 2 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle E. Last WISE		4. DATE OF DEATH DECEMBER 8, 1966	
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 12-3-1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carman		9. AGE (In years last birthday) 75 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA	
13. FATHER'S NAME WILLIAM E. WISE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-05-7749	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardiac Decompensation</i> DUE TO <i>Pulmonary Edema</i> INTERVAL BETWEEN ONSET AND DEATH <i>1-4 hrs</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO <i>Pulmonary Edema</i> 20 hrs (c) DUE TO <i>Plethoraclonus</i> 5 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <i>Home</i>
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 1, 1958</i> , to <i>Dec 8, 1966</i> , 1966, that (I) (we) last saw the deceased alive on <i>Dec 8, 1966</i> , and that death occurred at <i>9:45 AM</i> , <i>At Home</i> and on the date stated above.			
22a. SIGNATURE <i>Clay E. Durrett</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <i>12/8/66</i>
22c. PHYSICIAN'S NAME (Type) DR. CLAY E. DURRETT		22d. ADDRESS 236 VIRGINIA AVE., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 10, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Sunset Memorial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
		DATE DEC 12 1966	<i>Charles Judge</i>

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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16496

CERTIFICATE OF DEATH

16495

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 26 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First EDITH	Middle M.	Last WOLFINGTON
4. DATE OF DEATH DECEMBER 19 1966	Month Month	Day Day	Year Year
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH 3-15-1908	9. AGE (In years last birthday) 58 yrs.	10. IF UNDER 1 YEAR Months <input type="checkbox"/>	11. IF UNDER 24 HRS. Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) MARYLAND - FROSTBURG	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JAMES BURNS	14. MOTHER'S MAIDEN NAME NINA EICHHORN	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO.	17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 180X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) stating the underlying cause (c) Metastatic Carcinoma to lungs. Hypernephroma	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 3-4 days
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Diabetes Mellitus, Hypertension, Cardiovascular Disease	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11-25 1966 to 12-19 1966 , that (I) (we) last saw the deceased alive on 12-19 1966 , and that death occurred at 3:24 AM , from causes and on the date stated above.	22. SIGNATURE William P. James, M.D.		
22a. SIGNATURE William P. James, M.D.	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) DR. WILLIAM P. JAMES	22d. ADDRESS 441 N. CENTRE ST., CUMBERLAND, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 21, 1966	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Restlawn Memorial Park	23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.	ADDRESS	25a. REC'D. BY REGISTRAR DATE DEC 28 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16497

CERTIFICATE OF DEATH

16496

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach two carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 18 HRS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Memorial Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ALVIN	Middle G.	Last YOUNGBLOOD
4. DATE OF DEATH DEC. 29 19 66	Month	Doy	Year
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 10-5-88	9. AGE (In years lost birthday) 78 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Alense Corp of Am.</i>	
11. BIRTHPLACE (County & State, or foreign country) PAW PAW, W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES YOUNGBLOOD		14. MOTHER'S MAIDEN NAME ADA APPOLD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. -	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchial asthma DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 24-48 hrs many years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Art. C.V.D. - for years</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>10/13 1964 to 12/29 1966</i>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) LA VALE, MD.
20f. (City or town) (County) LA VALE, MD.		(State)	
21. I certify that (I) (this hospital) attended the deceased from 10/13 1964 to 12/29 1966 that (I) (we) last saw the deceased alive on 12/28 1966 and that death occurred at 6:45 AM , from causes and on the date stated above.			
22a. SIGNATURE <i>Thomas F Lusby</i>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 12/29/66
22c. PHYSICIAN'S NAME (Type) DR. THOMAS F. LUSBY		22d. ADDRESS LA VALE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/3/66	23c. NAME OF CEMETERY OR CREMATORIAL Sunset Mtns Ph
23d. LOCATION (City or Town) (County) Cumberland Md		(State)	
24. FUNERAL DIRECTOR <i>Lewis Stein Inc. Cumb. Md</i>		ADDRESS	25a. REC'D BY REGISTRAR DATE JAN 5 1967
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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